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## Tree Drugging and Therapeutics

WHAT wonders the jay reporter sees—with his cerebral eye! Here is one: A farmer, one of the Blue Hen's enterprising chicks, had a plum tree decrepit with age and past the period of bountiful fruiting. Boring a hole in the wood, the owner inserted a spoonful of calomel and plugged up the hole. Next season the tree, that before had yielded yearly but a handful of fruit, bore hundreds of quarts. Now the Delawarians are asking how the fruit is going to affect those who eat it.

And why not? Of late the farm journals teem with illustrated papers on tree surgery—why not tree medicine? We may thus develop a useful line of experiment that may aid in elucidating some obscure problems in human therapeutics.

But will this be the means of also developing a new variety of antivivisectionists? Methinks I scent the coming battle. If trees are affected by drugs, the trees must have nerves—a nervous system necessitates a center, a brain. This implies a mind, an ego, quite as a house implies a habitant; and this ego must have consciousness and the other faculties of a sentient being. How unjustifiable therefore to subject the poor,

defenseless tree to such outrages, for our own selfish purposes!

Already is taking shape the Society for the Suppression of Experiment upon the Vegetable World, with a central organization and many branches, State, City, Ward and Precinct. Some advantages will accrue to the founders of the new society. They will not be denominated the Association of Insane and Ignorant Meddlers, for that has already been applied to the antivivisectionists; nor the Miscellaneous Army of Cranks, for Battle Creek has preempted that cognomen; nor the Aggregation of Unteachable Wrongheads, for the antivaccinationists might sue for infringement of rights. In truth, it seems as if most of the apt designations for conglomerated silliness had been already utilized; but the resources of our language are incalculable and unexpected, and a suitable title will yet be devised.

More seriously—why not utilize the tree-drugging suggestion as a means of medicating humanity? Thirty years ago a French physician sought to establish a sanatorium in which he fed his patients milk from medicated cows; one lactiferous animal being fed upon arsenic, another upon iodine, and so along. Take the plums from

the venerable but hydrargyized tree and prescribe them for ancient but not venerable sinners who seek to enter the lists of Venus and emerge not unscathed.

*Why not?* If a plum tree responds to and imbibes mercury, why not a pear take up iron, an apple silver, and a peach phosphorus? Could not solidity be imparted to the melon by a hypodermic diet of lead? Could we not foster the blackberry on zinc, and develop a combination of tannin with the metal that would effectively meet the needs in the lesser war, the guerilla, of the Cyprian goddess? By treating our cucumbers with copper we might render more vivid their green, and at the same time endow the bowel-knotting delicacy with the antidote that smoothes out its angry kinks.

Truly, there would seem to open up a number of desirable ways in which the Delaware idea might be developed. But we dislike, in dealing with matters so grave as medical topics, to leave the ground of sober, settled fact and wander off in the byways of imagination. So we will leave the subject here.

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Success is only for those who are willing to stand by their standards—who are ready to endure the siege of misjudgment—who are prepared to face the fire of criticism and to accept defeat until they become vaccinated against it. Most men who gave up would have arrived if they had kept up.—Kaufman.

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#### THE WELL-MEANING MEDDLER

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When the motor gangs agley, and the curious crowd springs from nowhere to gape and gibe, they are chary about offering suggestions other than jocular. If anybody does presume to proffer advice it is pretty sure to be one who really knows something about such mechanisms. It is unimaginable that anyone of them would undertake to tinker at the recalcitrant machinery in so far as to risk himself in its guidance.

The human machine is complex and wonderful beyond the comprehension of the average mind. The medical profession has studied it for ages and is collectively ignorant of much of its workings. Many of its functions are as yet uncomprehended. Individually, there is not a doctor in existence who, after a lifetime of study and

observation, knows the mysteries of the human body so well that he can always intervene in its disorders with certainty.

Nevertheless, take that same yawping crowd that gather about the balky auto, and there is never a one—man, woman, or boy—who will not on the instant proffer and vehemently urge advice on any person who is ill or injured. We realize that it is the kindliest of impulses, the helpful instinct toward a suffering fellow creature, that prompts it, but for all that, there is something amazing in the ruthlessness with which people rush in with their advice.

Somewhere I picked up the following clever little skit, which shows that others, even of the lay press, have some realization of this absurd and perilous custom of volunteering advice:

"IN MEMORY OF I. WILL, BELOVED SON OF  
PLEASE AND WONTCHOO TRYIT, WHO  
DEPARTED THIS LIFE THROUGH THE  
KINDLY SUGGESTIONS OF HIS  
FRIENDS, JULY 2, 1910.

"Mr. Tryit was taken ill on Sunday with a severe cold. Sunday night, at the suggestion of his wife, he gargled his throat with antiseptic tablets.

"Monday morning he consulted a doctor, who touched his tonsils with nitrate of silver.

"Monday night he sipped hot lemonade at the suggestion of his sister.

"Tuesday morning his mother-in-law advised a gargle of salt and vinegar, which was promptly used.

"Tuesday night Mr. Tryit asked the advice of a neighbor and retired beneath a cold compress.

"Wednesday morning he arose and sipped rock-candy, flaxseed and lemon juice, prescribed for him by his niece.

"Wednesday night he took castor oil and donned a flannel nightshirt to produce sweat.

"Thursday morning he took strong ginger tea, brewed by a trained nurse who lived across the street.

"Thursday night he put on goose grease and snuffed camphor, at the instance of his grandmother.

"Friday morning his maiden aunt offered a solution of catnip and alum, which Mr. Tryit used as a gargle.

"Friday night his brother suggested golden-seal, carbolic acid and quinine.

"Saturday morning at 6:36 the end came.

"Only relatives and close friends will be present at the funeral."

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I learn of an eastern bank president who has been leading a double life during the past fifteen years. He has been chawin' tobacco during all that time and his wife didn't know it.—Beach's Magazine.

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#### OUR BUSINESS INTERESTS

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There appears to be a general impression that doctors are a sort of supernal race of beings whose minds are solely occupied with the recondite problems of disease, and who never descend to the level of common humanity, or think, talk or act in the planes where move their fellow men.

In truth the doctor is very human. He has a stomach that demands supplies, t. i. d., and he appreciates a good dinner, with time to eat it and no danger of being called out before the dessert. He has bills to meet and has to worry over making both ends meet. The fact that he has daily to grapple with problems whose solution means life or death renders him all the more capable of enjoying to the limit an interval of freedom from the cares that beset him. The chance to have a day off, to eat a good meal in peace, enlivened with the talk, the jokes and the laughter of others likewise freed, the chance to rub up against his fellow doctors, air his own views and hear those of the other men, makes these meetings pleasant and profitable. Nevertheless, as the time comes round for each successive meeting, most of us have a little self-communion over the question of whether we can afford it.

This is all wrong. These meetings should be so arranged that the only question each member asks himself is, "Can I afford to miss it?" As one way to render a society meeting so valuable that no member could afford to miss it, I would suggest that one paper with discussion be devoted to that

part of our duties most difficult and most essential to our success, our business interests. The present paper is presented with the hope that it may initiate the custom, and with a view of arousing plenty of edifying opposition I shall make such radical statements as you will surely oppose:

If the population of America were equally divided among the registered physicians legally entitled to treat them, each of us would have about 500 patients on our lists. But these we share with innumerable illegal practitioners of so many breeds, cross-breeds and mongrel varieties, that it is impossible to list them.

Why should people leave regularly trained physicians, who have spent years in studying the human body and its ailments, successfully passed many examinations and proved their proficiency, and place their lives in the hands of persons who never had any such training, and whose readiness to undertake a case is the most convincing proof of their ignorance? Nobody does such a thing with his automobile, or the plumbing of his kitchen. Let us dissociate ourselves from the matter and consider it impersonally, as a phenomenon that has a meaning, to be traced to its cause.

It is impossible to avoid the conclusion that a large section of the public does not like us, or believe in us, but resorts to anybody, however illiterate, and anything, however absurd, sooner than apply to us for relief. Naturally, we feel that we should make ourselves more worthy, and so we increase the vigor of our entrance and graduating examinations, bring up the grade of our medical schools, and institute independent state examining boards; but instead of seeing a return of public confidence we find the gap between us and the public widening.

Is it possible that the difficulty lies in the elevation of the profession, creating a gap between us and the public? Men have always clung to those who, springing from their own ranks, remain a part of them. The demagog's strong hold on the ranks is due to this fact; he is from the ranks, knows the people, their needs, their possi-

bilities; he is one of them; while the aristocrat seems ever like the princess who, being told the people had no bread, suggested that they eat cake. The religions that spring from the people, when the comrade of today becomes the priest of tomorrow, enjoy a popularity never accorded the highly finished product of the seminary. Samuel Thomson had no education, lay or medical, and so little appreciation of what the science of medicine means that he judged of the properties of plants simply by tasting them; yet he inaugurated a movement that swept the old practice from its moorings and compelled the relinquishment of its most tried and trusted remedies.

We should beware lest the uplift of the profession result in lifting it up onto a pedestal where it stands as an ornament to be admired but of no particular use. The search for more knowledge will and must go on, but it might with advantage be directed to the study of the useful rather than to the abstract. If the public has formed the impression that we have become "too scientific" to care for the patient individually, that we are too interested in watching the course of a disease to be willing to interfere, there is unfortunately too much reason for such a belief in the utterances of high-up men in our ranks.

The statement that "there is no treatment for pneumonia" has driven thousands to our competitors. The slurs thrown on our *materia medica*, by men who should have known better, have been taken as the belief of the profession; and the people have taken us at our word—our remedies are worthless, and we as well. "Then ho! for the Christian scientist, the osteopath, the Weltmerist, *et id omne genus*. You acknowledge you are useless, they promise everything; we lose nothing by leaving you."

In vain we seek to retract; we did not mean it; we were only joking; we can do all and far more than the quack. The public looks over what we have to offer—"same old stuff, nasty as ever; we know all about it and have no inclination to go back to the rotten trash."

But, we can use the same things the quack employs!

"Oh! so he was right after all, and now you own up to it; and *we* were right in supporting him. Well, the man who introduced it is surely better than his imitators." Our efforts to fight quackery with its own weapons merely give the quack our endorsement. It is a surrender, not a conquest.

The true remedy is so obvious that I wonder it is not universally recognized. We must study our patient more in the sick-room, and must learn to treat him. We must use the best means of treatment and apply them more skilfully. When we come to study our patient at the bedside we occupy ground on which we are impregnable, for not one of our competitors can approach us here.

The old *materia medica* is doomed. Profession and public are tired of it, dissatisfied with it, will hear no good of it. But we make a mistake in letting the outsiders introduce the novelties. Novelty is the one thing above all others that recommends a therapeutic method. People continually ask what there is new, and are ever ready to give it a trial. The alkaloids have this primary advantage to the public, they are new and very attractive. The power lying in the little granule appeals to the imagination, which means much. Their small dose, absence of unpleasant taste, quickness in getting to work, and the precision with which they can be applied are decided advantages.

The use of remedies whose action is certain and unvarying leads the doctor to more careful study of his patient in order to grasp correctly the conditions against which these remedies may be directed. The fact that they are remedies for conditions rather than for diseases leads us to study the individual patient and to resolve his malady into its factors rather than hunt for a specific for the name of the disease.

The more we study the individual patient and the closer we apply treatment to his individual case, the firmer becomes his faith in us. He doesn't want erudition but help. He cares less to know that ninety percent of cases like his get well than that he himself will recover. He cares less for the interesting diagnostic features of his case than for ease from his sufferings.

Every element of success in our fight for the recovery of the public is to be found in the alkaloids and the methods made possible by their use. I would especially specify here the possibility of early and effective intervention in breaking up attacks of acute fevers. Only by striking hard and straight a knock-out blow before the malady has had time to establish itself by structural lesions can this be done. But we dare not strike thus, unless sure of where our weapon will hit and that it will do just what we wish. Uncertainty breeds timidity, and this spells ineffectiveness.

The men who only use weak, uncertain and ineffective drugs, in which they do not really believe, deny the possibility of jugulating such attacks. We who know that digitalin contracts dilated vessels, that aconitine relaxes spastic vessel-walls, that veratrine opens up vessels and eliminates, that strychnine arouses the vital forces, that atropine actively dilates the capillaries and increases capillary attraction, that gelseminine allays cerebrospinal hyperemia, irritability and pain, that berberine contracts relaxed connective tissue, and that one hundred other remedies each do exactly the things we know they can do, not sometimes or generally, but every time, we also *know* that when we see any such disorder in a patient and apply the remedy that corrects that disorder, it must and will correct it every time. And if correcting the disorder manifested is not curing the patient, it is a mighty satisfactory substitute. We need not go to the outsider for our novelty; we have an infinitely better one developed by ourselves.

Every element for popular success is to be found in this suggestion. It is a reform strictly developing within our own lines, originating and operated solely by ourselves; it is perfectly comprehensible to ourselves and to the intelligent laity; and yet there is the element of mysterious powers residing in the little bulk that appeals to the imagination. It shifts the fight against quackery to our own territory where we are safe from every sort of opposition. Moreover, its practice is so easy, because so natural, that as soon as one gets a little accustomed to the absence

of the old difficulties he wonders how he went so long without realizing its advantages.

To treat the disorders one sees rather than wait for the book diagnosis may not seem very important or even desirable, but it is the dropping of an unnatural method and the restoration of the true one. Bastin, in the preface to his excellent "School Botany," says that botany is the study of plants and not a study of books about plants. That is exactly the idea—we have been studying books about disease too exclusively and disease itself too little. To practise with the active principles one is compelled to study his patient as well as his books.

*It beats the deuce how the folks will weep as you lie in your coffin so fast asleep, and sing of your goodness in countless ways while the parson preaches and talks and prays. 'Tis queer how the public will eulogize and laud you up to the vaulted skies, when the undertaker has called your bluff and squirted you full of embalming stuff. But when you walked on the earth, I swear, you were nothing more than a plodder there and you'd have fainted or dropped down dead at any praise that the public said. It's only when you're a lifeless stiff that the heartless public will note to the diff.—Walt Mason.*

#### THE PURE-FOOD LAW AND PRICES

In the midst of the universal acclaim of this movement in favor of pure food, a still, small voice begins to make itself heard, in ever increasing volume. The theme of its song is the increase in the cost of living.

What do people expect, anyhow?

You kick about having ten percent of terra alba in your wheat flour and in addition twenty percent of ground maize. But why, then, in the name of common sense, cry out against a raise of fifteen percent in the price of the article when really pure and unadulterated wheat is now supplied? You have been accustomed to spices containing eighty percent of powdered olive pits, and now find yourself charged five times the old price; yet, you are a gainer, for your pepper goes five times further, and you are saved the cost of the useless adulterant, not to mention the improved flavor.

You are now able to choose between real cocoa and that diluted with divers and sundry adulterants; and you know what these are, and are relieved of the haunting

suspicion that you are consuming bullock's blood and various other still less appetizing diluents. You can choose between mixtures of maple syrup and glucose, and pay the price for the natural sweet—if you can get it. You note that what you have been eating as currant, strawberry, raspberry or other brands of jelly are really currant—and so forth—plus the core and peel of inferior apples; and you can eat the pure unmixed jellies you supposed you were getting—provided, let us breathe it gently, your good wife will put them up in her own kitchen and has the fear of the Pure-Food Law in mind. You may be happier to know that the brand of coffee whose subtle flavor so tickled your palate owed its peculiar twang to an unsuspected admixture of chicory.

But there are other points in which the questions become complicated. Take that of ice-cream. The delicacy vended under that designation consists of a variable mixture of milk, sugar, eggs, gelatin, corn starch, arrowroot, and the flavoring. It sells for twenty-five to thirty-five cents per quart. The component elements are, presumably, pure, wholesome and unadulterated; the result is what people are used to and want—an agreeable, cold and cheap dessert. Just buy a quart of real cream at not less than forty cents, add the sugar and flavor, and freeze it, and see if you could sell it at less than sixty cents per quart and pay expenses. People will not pay that much; and if they did, it is not everybody who could digest a food as rich in fat.

Make an arbitrary ruling that ice-cream must consist solely of pure cream, sugar and flavor, and the ice-cream trade is disrupted and completely ruined. The law might with propriety compel dealers to distinguish between the ideal ice-cream and the commodity to which we have been accustomed, by designations that may be comprehended by the purchaser. We would then be able to secure "pure ice-cream" if we pay the price; or regale ourselves more plenteously at less expense with the plebeian product.

It may be questioned whether the law should compel the manufacturer to give the ingredients. Do the producers of Wor-

cestershire sauce give the formula? Certainly not—that is a trade secret. Publish it and every *chef* in the world would supply his guests with his own make. The law has not as yet made trade secrets unlawful, the purport of the pure-food act being to prevent the substitution of inferior, cheaper or unwholesome substances for those described by the label and of good quality. In many cases we suspect it would be impossible to give the ingredients of a food that is not always the same, as India relish, no two jars of which are identical; or such concoctions as the gumbo that made New Orleans famous.

When such complications arise it is invariably the custom of those entrusted with the enforcement of a law to push it to the limits of its letter, even if injustice result, leaving to the law-maker the task of remedying such defects by amendments. It is this that makes law-making interminable and law a jungle. Should common-sense and equity be allowed to rule in exceptional cases it would be easier to assimilate new legislation, although the burden of responsibility on judge, jury and legal officials would be enormously increased. It is easier to say black is black than to decide whether black is always black.

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Fix not your heart on earthly good or gain,  
Life means but pleasure or it means but pain;  
When time lets slip a little, perfect hour  
Oh, take it—for it will not come again.

—The Rubaiyat.

#### BETTER COUNSELS PREVAIL

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We are glad that the counsels of overzealous leaders in the National Association of Retail Druggists who were determined to enter upon an open warfare with dispensing doctors were in large measure overruled at the last meeting of the association, held in Pittsburgh in September. The resolutions proposed by *Notes*, to which such wide publicity were given and whose passage was urged with such unwise ardor, were passed in a much modified form. Instead of demanding the suppression of dispensing through legal enactment the druggist-body

simply placed itself on record as being "*opposed* to the general compounding and dispensing of medicines by physicians," called upon the medical profession to prevent, as far as practicable, "the compounding, dispensing, distribution and sale of medicines by physicians," and urged the enforcement of the medical-practice and pharmacy laws, in the interest of both professions.

On the whole the resolutions were temperate and in the main reasonable. We are firmly of the opinion, as many times stated in these columns, that the best, indeed the only, method by which the druggist can hope to secure the patronage and support of the physician is through his ability to co-operate with the latter. Just to the extent that he can demonstrate the desirability or the necessity of his services will he succeed in enlisting the interest and securing the business of the physician. He will never succeed in this by the threat of "getting the law" on the medical man, and efforts directed along these channels will inevitably result not only in failure to increase the size of his prescription file, but will intensify the old feeling of bitterness, where one exists, drive away trade, and effectually prevent the drawing together of the members of the two professions into the closer relationship which is really so desirable.

Dispensing on the part of physicians is here to stay. It is the natural response to social, economic and professional conditions which the wise man will understand, and if he is gifted with a sufficient sense of business acumen, turn to his own profit.

The lemons make nice lemonade. There is no reason why doctors and druggists should be shying this beautiful and useful fruit at one another. Now that the heat of the battle is past, we advise our good friend *Notes* (we are essentially friends after all) to settle down into a campaign of *friendship* with the doctors—yes, dispensing doctors—abandoning for all time its defamatory editorial tactics of the last few months.

We pledge our hearty cooperation in such a campaign of friendship, as based upon fair consideration of one profession for the other, without any suggestion of coercion, and with

the predominant thought of giving the patient the best possible service—which is, of course, the thing of highest importance.

But we stand for the doctor, and attacks upon him, whether he dispenses or not, no matter what his sectarian affiliations, provided he is square, honest and intelligent, trying to do his level best, we shall resent, and when such attacks are made we are prepared to fight for his interest, and fight like —!

What some economical (?) people keep from the doctor they give to the undertaker—and then some.—W. A. Evans.

#### TYPHOID FEVER IN CHICAGO

The members of the North Shore Branch of the Chicago Medical Society at its last meeting (October 7) were favored with an exceedingly interesting talk by Dr. L. L. Lumsden, who had been detailed by the Public Health and Marine Hospital Service to cooperate with the Chicago Department of Health to make an exhaustive study of the typhoid-fever situation in this city. Not that the morbidity from this disease is high here; indeed, the contrary is the case, and Chicago is probably freer from typhoid than any other important center of population in the country. But there are many questions to be answered, many problems to be cleared up, and it was thought desirable by Commissioner Evans that these should be undertaken in a thoroughly intelligent and systematic way.

We learned, for one thing, that the death-rate for typhoid fever in this city has been falling more or less steadily for the last fifty years. During the epidemic in the early '90s it reached more than 95 per 100,000. For the ten-year period preceding the opening of the drainage canal it exceeded 60 per 100,000; the next ten years it fell to an average of 23, and now it is only 12 per 100,000.

The drainage canal has removed largely the danger of transmission by drinking water; yet Dr. Lumsden showed that there is still likelihood of contamination from the communities to the north and south, which

empty their sewage into the lake. Dr. Young, of the Marine Hospital, pointed out that the excursion steamers, running into and out of the port of Chicago, deposit near the water-intakes, many days during the summer, the excreta of thousands of passengers, and neither city, state or nation has any control of the sanitary condition on these boats. Among the patients at the Marine Hospital he has had typhoid-fever patients who were members of the crews of these boats, some of them cooks, waiters, dish-washers, and others coming into contact with food.

Dr. Lumsden named as the causes at present most concerned in the transmission of typhoid fever in Chicago: the milk supply, typhoid carriers and personal contact.

Our milk supply it seems is generally good; yet it is exceedingly difficult to be sure that on some of the thousands of farms supplying this great city or among the many men engaged in the distribution of milk there are not cases of this disease. A number of small foci of milk infection were indeed discovered; all the cases in one neighborhood, for instance, being traced to the customers of a single milkman, and from this source of supply back to cases of the disease on farms. In one case a farmer selling milk for city consumption was found to be harboring two cases of typhoid fever, one of them of several weeks' standing. He belonged to a religious sect opposed to the use of medicine and these persons had been without medical attendance.

The bacillus carrier is a greater danger than is generally appreciated. Dr. Lumsden states that from 2 to 4 percent of those who recover harbor the germ, which is discharged either in the urine or stools, or both. There are also apparently healthy persons who have never had typhoid, who also are "carriers." In this connection Dr. Edwards' warning to look out for the atypical cases was pertinent. This speaker said that he had seen several cases in which there was apparently no elevation of temperature whatever, and he described another case, now under treatment, in which the febrile symptoms were inconsequential, the most

prominent symptom being headache; yet the diagnosis was positively shown by blood examination and the Widal test. Lumsden believes that the "carrier" should be sought for, and when found, excluded from those occupations which bring him into contact with food. He should not be allowed to work in bakeries, meat-markets, grocery-stores, restaurants, nor in the gathering or distribution of milk.

The essayist expressed it as his belief that a large number of cases of typhoid fever in Chicago now result from direct contact. In other words, it should be considered as essentially contagious. It is remarkable how inadequate are the precautions adopted to prevent its transmission, even in the practice of able physicians, who are giving the patient good medical care. He thinks that about 4 percent of the Chicago cases are acquired in this way, which, while too high, is low as compared with Washington, where about 20 percent are secondary.

It should be emphasized that every case of this disease comes, either directly or indirectly, from some other person who has or has had the disease. It may be communicated in the early, even in the incubative, stages, and according to one authority this is most frequently the case; so the physician should be on his guard from the very beginning. Even before the diagnosis can be accurately made it can be "suspected"—and it is at this time that the campaign of prevention, meaning cleanliness, individual asepsis to the surgical degree, and perhaps hospitalized isolation, should be begun. We should add, that this is the stage for the most effective therapeutic campaign as well.

In Chicago less than 25 percent of the cases are imported, i. e., brought here from out of the city.

The discussion was of considerable interest, though nothing of very special value was added as to methods of treatment. The value of diet, and its proper selection, hydriatic methods, etc., were dilated upon at some length. More than one speaker insisted upon the importance of treating the patient rather than the disease. One

speaker took occasion to condemn the use of intestinal antiseptics as irrational, on the ground that the disease was a bacteremia from the start, and therefore beyond the reach of the therapeutic sterilizing agent, even before the diagnosis could be made. And, yet, it was significant that nearly everyone speaking noted the remarkable change in the condition of the severely toxemic patients when alimentary disturbances were corrected, by diet or otherwise. Has it not occurred to these gentlemen that the correction of alimentary toxemia is a prime factor—yes, *the* prime factor—in treatment? No condemnation of the antiseptic method was made (or could be made) upon clinical grounds, as thousands of readers of this journal are prepared to testify.

The evening was a profitable one in every way. It is plain that Chicago is to be congratulated upon having had the services of Dr. Lumsden, whose investigations here are certain to accrue to the advantage of the entire country and to humanity as a whole.

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The occasional fanatics in medicine—Savonarolas in science—are needed.—W. J. Robinson.

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#### FOUR EPOCHS OF LIFE

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Of all the problem-books, or to be more specific, of all the books dealing with the problem of sex and with the cure of the social evil, none has impressed us so deeply as has the one written by Dr. Hamilton-Muncie bearing the above title. (See Book Reviews.) In the form of a simple and attractive love story, the love story of a married couple, the author brings up and discusses, fearlessly but with a sweet womanliness and deep understanding of human nature, the relations of the sexes in childhood, adolescence and in adult life; the training of the children for the purpose of unfolding to them, early in their little lives, the mysteries and beautiful truths of nature. Although the story as told seems almost Utopian and we sigh regretfully when pondering the overwhelming obstacles that combat its being translated into actuality, it is withal so

attractive and so simple that we cannot but wish that we might have had a "Doctor Robert" for a father and a "Doctor Ruth" for a mother.

The problem of how to inform the children, the young boys and girls, the young men and women, in questions of such vital interest but of such delicate nature appears easy enough—while reading the book; but where are we to find the teachers, the parents with the requisite knowledge and tactful wisdom and firm discerning love who shall know how and when to teach?

The author evidently believes in the regulation of procreation and of the number of children; for the heroes of the story, the doctors Robert and Ruth Lyon, live together for three years without progeny, and then the procreation of their first offspring is deliberately planned and executed. We wonder how the author imagines the marital relations of this charming couple during the first three years of their married life? Did they deliberately and entirely abstain from eating of the fruit of the tree of knowledge, as the only certain means of preventing conception, or did they use anticonceptional measures?

We do not agree with Mr. Roosevelt and Emperor William in the indiscriminate production of children. We believe that the number of children and the time of their birth should not be left to chance; though we also believe that the larger family is usually the most happy; that each little newcomer gives every other member of that family a broader and less selfish outlook upon life and a greater likelihood of real success. We also agree with the author in her contention that the advent of children should be intended and desired and that their upbringing and education should be along the lines laid down in the book, the many interesting phases and problems of which we cannot possibly discuss here. The author illustrates a most beautiful "selection of species," and traces the mental development both of parents and children in so attractive and charming a manner that we can only regret the all but unsurmountable obstacles to its ever becoming true.

The terrible facts connected with the social evil, the white-slave traffic, the far-spread distribution of venereal diseases, and other similar evils are mentioned plainly and without fear, and yet not in a manner that could give offense to any right-thinking man or woman. The author is right in her contention that the ignorance of possible evils is not a protection, but rather that only knowledge imparted in a proper manner can afford that and can form the character so as to render the dangers innocuous. The Nature Stories of Dr. Ruth are beautifully conceived and beautifully told and might well serve, not so much as a substitute for than as an extension of the fairy tales which now form the mental pabulum of children.

Speaking of fairy tales, we do not consider them wrong or untruthful. Grimm's and Anderson's tales could be made of as great importance and could well be used to unfold and illustrate the workings of nature in the same manner as do the Nature Stories. Is not the story of the sleeping princess, for instance, founded as it is upon the awakening of Brunhilde by Siegfried, based upon the mythos of the white god Balder and does not this illustrate the awakening of the ice-and winter-bound Mother Earth by the kiss of the sun-god?

We urge every physician to study this little work carefully, to loan it to the fathers and mothers of his clientele, and especially to the young men and young women in his care; also to call the attention of teachers and lawyers to it. However desirable it is that the parents should instruct their children in the truths of nature, they must themselves first learn; and for a long time to come the duty of a teacher will devolve upon the family physician.

We consider it of particular importance that medical students and young graduates should be given the book for study, because it will be of immense assistance to them when they go out into their professional lives.

In connection with this important subject we also call the attention of our readers to a leading article by Dr. Standard, on The

Crime of Sexual Ignorance, which deals with the same questions.

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Don't get any false sense of security through being told that typhoid fever is "not contagious." It is communicable from person to persons every case is caused by disease germs which have come in some way—water, milk, fingers, food, flies—from the *dejecta* of some previous case.—William A. Evans' "Healthgrams."

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#### THE SOCIAL SIGNIFICANCE OF ORGANIZATION

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Fifty years ago, when the experiment was tried of importing English locomotives for use on American railways, they proved a failure. English roads were carefully built, leveled and ballasted, and their engines were tightly braced to run over perfect road-beds. Our roads were hurriedly constructed to cover long distances, and with a sparse population cheap construction alone made them possible. The American locomotive was adapted to such trackage by an elasticity of construction the English machine did not possess. Now, however, our roads have been so improved as to rival the English perfection, and with this the type of our engines has been altered so that they now correspond with the British type.

Our ancestors found the conditions of life in Europe unendurable, and they crossed the world, braved the privations and perils of pioneer life, to escape from them. Society in the Old World was then organized under governments largely despotic, everywhere burdened by caste. After incredible hardships and exertion we cast off the yoke and founded our rustic commonwealth on the basis of individual freedom.

The ideal was, as little government as possible and the greatest dependence on the individual citizen's sense of rectitude. Under Jefferson this principle was systematized into a political party, where it received a general and passionate adherence the like of which has never been equaled. With a widely-scattered population, almost exclusively agricultural, the Jeffersonian democracy comended itself to the instincts of free men.

Times change. The land fills up; manufacturing becomes our predominant industry,

and the descendants of the original American settlers are engulfed by a constantly rising tide of Europeans who are accustomed to the restraints and support of a paternal government. The illimitable stretches of fertile soil, that offered a refuge to the men who wanted "elbow room," have reached their limits. The impulse remains, the land-hunger is yet there, but the outlets are closed. Individual responsibility and rectitude become sadly checkered by individual greed. The fertility of our social field has permitted the luxuriant growth of the weeds of conspiracy, monopoly and corruption. Wealth and power encroach on public and private right, and there is a constantly increasing demand for legislative protection of the masses, against them and the corruption of the legislators.

The law, revered by our grandsires to such a degree as to excite the amazement of De Tocqueville, has become the refuge of the dishonest, the arena for keen and unprincipled experts; and even the judicial bench is not above the suspicion of corporation control.

Just as these conditions increase, with the thickening population, so does the demand for organization grow. Jeffersonian democracy is dead. Capital combines. Labor combines. The combinations of various allied interests jar, as their interests clash, until they necessarily form combinations of combinations, while the organizations of workmen unite into amalgamations and federations. The transportation conspiracies are successfully held to reason and their extortion is checked only by unions of producers—and woe to the melon growers of Texas or the orange raisers of Florida if they cannot form unions of bulk to vie with the fruiterers of California. Woe to the individual who stands alone in any vocation not yet solidified in organization. He is between the upper millstone of capital and the nether millstone of labor—he is the grist itself.

The railway needs iron, the iron trade needs transportation, and they needs must combine. Other trades must be drawn in, in turn, and this process must go on until we have a union of trusts, a union of labor, a

unification of all interests and industries. This is the tendency, and, in the opinion of many, such a universal socialization of industry is inevitable.

I am not defending this idea. It is loathsome to one in whose veins runs the blood of the pioneers, to whom the Jeffersonian principle is the dearest of ideals; but I am conscious that it is now being crystallized into a political faith, and that the end is not yet. Even now personal rights can only be secured and maintained in the ultimate by the association principle, and in modern phrase, this is socialism; which means the very antithesis of the ancient idea of independent, self-respecting, personal freedom, and moral responsibility of the individual. In other words, the Roman is conquering the Teuton, and "liberty" replaces "freedom."

The medical profession is not exempt. Its organization is as inevitable as that of the trades and other industries. Resent it as we may, we must submit to what neither we nor any other human force can prevent, for the laws of cause and effect are inexorable. There remains to each of us the duty of participating in the organization, and lending whatever influence we may possess to making it the best that such an organization may be made. There is as much room as ever for individual rectitude, for honorable example and precept—and there is more need for them than ever. In one way there is advantage, for the influence of a man for the right may be widely extended by the very organization that limits his own individual rights.

Face the music, Brethren! Banish vain regrets, and rather seek to adapt and utilize the new conditions for the general good.

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I'd like to know the use of ability if you don't get right out into the thick of things and use it.—*Beach's Magazine*.

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#### INFANTILE PARALYSIS

One of the interesting facts revealed by the last census is the large number of deaths which occurred during the year 1909 from acute anterior poliomyelitis, or infantile paralysis. There were 569 ascribed to this disease. This is the first time that it has

been recorded as a cause of death by the Census Bureau. A few years ago, while recognizing the danger of paralysis with permanent disability, the mortality from it was assumed by the leading textbook writers well-nigh as nothing. The record of recent years has proven this assumption to be untrue. According to Osler there was a mortality of 6 or 7 percent in the New York City epidemic of 1907-8, in which there were about 2000 cases. At the May, 1910, meeting of the American Congress of Physicians, held in Washington, a resolution was adopted in which it was stated that the disease is an infectious and communicable one, having a mortality of from 5 to 20 percent, and that 75 percent of those who survive are permanently crippled.

Infantile paralysis is epidemic in nearly all parts of the country at the present time, if we can judge correctly by numerous reports that have come to us directly and indirectly. A number of our readers have requested information and help, especially in its management. It is significant of the present epidemic that the disease is not confined to children, though, as would be expected, the largest percentage of cases occur during the earlier years of life.

Undoubtedly many readers of CLINICAL MEDICINE have had experience with acute anterior poliomyelitis. Will these brethren not enrich the "family" with records of their successes and failures? The great need is to get light on its treatment—and of course on its prevention. We shall welcome the receipt of a number of short articles upon this subject.

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To greatly increase your chances of avoiding typhoid fever—swat every fly in your house.—W. A. Evans.

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#### "SCIENCE AND HUMANITY", AND TUBERCULOSIS

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Under the above caption Beverly Robinson contributes an editorial to *The New York State Journal of Medicine*, in which he discusses a matter that lies close to the heart of every lover of the medical profession, of every member striving for a high ideal.

A patient, a young man on the first rounds of that ladder that most surely leads to influence, the public press, engaged to be married, is found to be tuberculous. The doctor's duty is clear—he requires the man to lay down his work, cease all thought of matrimony, and banish himself to the country where he can live according to the rules most likely to eventuate in a cure. His life-work henceforth is to wage war against the tubercle bacilli that have effected a lodgment in his body.

The laity have become so imbued with the belief that tuberculosis is contagious that in their minds little distinction is made in this respect between it and smallpox. They can not comprehend that there is a difference, that, as Robinson correctly says, tuberculosis is only contagious to the relatively few susceptible, and then under particular circumstances. Those most susceptible may develop tuberculosis, no matter how great the precautions; those only inadequately susceptible require exceptional and prolonged exposure. Disregard of these facts leads to much unnecessary distress.

How far is the detection of tubercle bacilli in the sputa to be trusted as indicating an infection of the lung? Or as to the prognosis? Neither are absolute, according to the very latest investigations. The morphology of this organism varies, as does its reaction to chemical agents, and also its infective power as determined by inoculation of cavies.

Even leaving the bacillus out altogether, the same advice is due to the patient. But he should not be also crushed flat by an exaggerated and untrue estimate of his condition and the danger it presents to others. During his thirteen years' service among the pulmonary classes of a great city hospital Dr. Robinson knew of no case of tuberculosis developing among the assistants, often crowded for hours in rooms rarely if ever renovated or disinfected.

Dr. Robinson thinks it is not proved that cures of pulmonary tuberculosis are more frequent now than they were at that time. Even now many fatal relapses occur after sanatorium "cures." Were the funds now

devoted to supporting sanatoria employed for improving the living conditions of the poor, Dr. Robinson believes better results would be secured in the way of eradicating the disease. Very many pupils in the public schools are now tuberculous and disseminating the infection in the streets, cars, and other public places.

What he has said of tuberculosis applies alike to diphtheria, only in a different manner. Here, besides the Loeffler bacillus, there is the personal equation to be considered, the exposure, and the unknown susceptibility at a given time. To this, however, I wish to add—and that most emphatically—and the environment. The lesson of the connections, in diphtheria, between bad hygienic conditions and malignancy was burned into my mind by my experience as medical health officer—an experience I would wish every colleague could have shared.

Dr. Robinson was house-physician to a children's hospital in Paris, with a diphtheria ward. Although poorly fed, over-worked, repeatedly inoculated in the course of thirty tracheotomies, he yet escaped infection. Years later, caring for a mild case, under the best conditions, he contracted the disease and narrowly escaped death from it.

Our power of avoiding or preventing contagious disease is very limited. Epidemics vary, as does individual susceptibility. We have in other infections no such resources as in smallpox and diphtheria, although the latter are by no means infallible.

The health office tells us not to fear disease transmission by fomites, or to believe pulmonary tuberculosis any more contagious than it has been, or that the bacillus is so very frightful after all. It tries to tell the victims of tuberculosis to be rational, to go live rurally for a period, eat good food, take just enough exercise, and help with the right medicines, and holds out the hope that then the malady often ends by self-limitation. In the meantime let humanity direct our advice.

This fine editorial ends as follows:

"I would add one thing, and only one, and do so because of its immense impor-

tance. *Vaccination* should be absolutely obligatory. A senseless segregation and quarantine would then be unnecessary, just as the Japanese and Germans have shown—because there would be no people to take smallpox and the disease would cease to exist. 'What fools these mortals be?'"

With the latter sentiment especially I heartily coincide.

There may be such a thing as too much conscience, but there is no such thing as too much common-sense.

#### CHILDREN EMPLOYED AS SCAVENGERS

*The Chicago Medical Recorder* for August editorially calls attention to the faculty of Milwaukee's socialist mayor of saying many things in a way that are attractive to the newspapers because they are of educational value to the public. "In a recent interview with reference to keeping the streets and vacant places free from litter, he suggests rewards for children who aid to the greatest extent in removing litter from the streets."

Although *The Recorder* does not explicitly approve of Mayor Seidel's suggestion, the tone of the editorial permits us to take such an approval for granted, and we feel constrained to take issue with the idea. If Mr. Seidel "suggests rewards for children who aid to the greatest extent in removing litter from the streets," he is either not cognizant of or forgets the fact that children are, as a rule, peculiarly susceptible to the pathogenic action of virulent microorganisms which can almost invariably be found in greater or less amounts in the street dust and in the street litter.

Supposing that a child, in its anxiety to earn a promised reward, picks up all the loose paper littering the street, and some of these bits of paper have been handled, coughed and perhaps spat upon by a consumptive, who shall say that sufficient time has elapsed for the light, diffuse or even direct, to exert its germicidal power? Or supposing that one of those scraps chance to be contaminated with the virus of scarlet-fever or of diphtheria, will not the child handling that paper, stuffing it into a bag,

and then maybe wiping its heated little face with those dirty hands or solacing itself with a bit of candy while thus engaged, almost surely be infected and very probably acquire the disease?

There are still worse possibilities connected with the plan, but those mentioned may suffice. We should most emphatically object to employing children as scavengers. Let the work of the latter be done by those who have acquired a certain immunity to infectious microorganisms, either through age or through habituation from years of contact.

By working for the good of all we work for the good of ourselves. We only succeed as we work for the good of the whole.—Elbert Hubbard.

#### MISTAKING TYPHLOCOLITIS FOR APPENDICITIS

In *Le Monde Médical* for August appears a lecture from Professor Dieulafoy, of the Academy of Medicine in Paris, in which he discusses the relations of true appendicitis with the maladies too frequently mistaken for it.

Dieulafoy denies the tendency of typhlocolitis to end in appendicitis, and asserts further that operation for a supposed appendicitis when the patient is suffering only from mucomembranous or sandy typhlocolitis is indefensible. He nevertheless is "one of the most ardent advocates of surgical intervention in the treatment of appendicitis."

"I have," Dieulafoy says, "invoked surgical intervention in a very large number of cases of appendicitis, and the farther I go the more convinced am I that it constitutes the only effectual, rational treatment. The removal of the toxinfestive appendicular focus before it can prove fatal is a common-sense rule of conduct which is confirmed by everyday experience."

After expressing himself thus emphatically, Dieulafoy proceeds to enter his protest against operations for nonexistent appendicitis on persons suffering from typhlocolitis and the attempt to bolster up the diagnosis by histologic examinations in defiance of

clinical observation. He records no less than nineteen cases in which the operation for appendicitis was done but no appendicitis found, the malady being typhlocolitis, and recurring after the operation as it had done before the same.

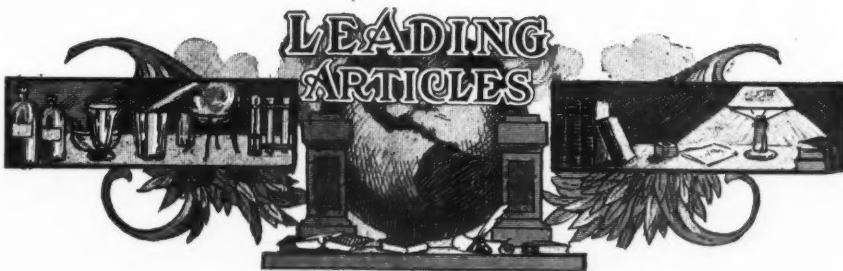
The expensive and perilous operation was done despite the fact that the diagnosis excluding appendicitis could readily have been made. The patient suffers severe abdominal pains and which are recurring, the abdomen is tender, especially over the colon, and pressure over the right iliac fossa occasions cries of pain, indicating this as the focus of the malady. If the physician is imbued with the pernicious doctrine that typhlocolitis often ends in appendicitis, he will operate, only to find himself, to his own and the patient's chagrin, contradicted by a healthy appendix.

Now comes the microscopist, who proceeds to justify the operation by discovering a "histologic appendicitis," invisible to the unaided senses and occasioning no symptoms.

Folliculitis, simple or hemorrhagic, is not appendicitis in the sense of justifying operation. Letulle has studied this intra- and extrafollicular hemorrhage of healthy amputated appendices and shown it to be due to the operation itself. Heubner, in conjunction with Noeggerath, reached the same conclusion, after a series of experiments on rabbits.

"What, then, remains of the microscopic appendicitis? Nothing at all! Anatomically it does not count, clinically it is nonexistent; yet this is the principal basis of the theory according to which an attack of appendicitis is commonly a sequel of enterocolitis."

The operation has no effect on the recurrence of the painful attacks, predominating in the right iliac fossa. Apart from certain neurasthenia cases, the mucomembranous enterocolitis pursues its course after as it did before the operation. Thirty-five cases are quoted to prove this point. Many become obsessed with the idea of appendicitis and beg for operation to relieve their apprehensions.



## The Crime of Sexual Ignorance

*Showing Why the Doctor Is to Blame*

By D. E. STANDARD, A. M., M. D., Springfield, Missouri

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**EDITORIAL NOTE.**—Dr. Standard uses strong and unsparing language in his wrath at the terrible conditions and ignorance prevailing in regard to sexual questions; but we consider him in the right and commend his article to the careful study of our readers. We also refer them to an editorial, in this number, on the same question ("Four Epochs of Life"), and to the book with this title, by Dr. Hamilton-Muncie, which is discussed in the review department.

I THINK the time has come in our advancing civilization when as much stress is being laid on the ability to prevent disease as to cure; and when we come anywhere near being half way to what we should be, as scientific men and women, we shall place very much more stress and honor upon the doctor as a man, or doctors as a profession, whose ability is marked as a preventer as well as a curer of disease. It takes not the eye of a prophet to see that the modern medical science is directed toward the prevention of disease.

It ought to be a crime, and I believe it soon will be, for a physician in any locality to see or know of contagious or infectious diseases, or of cesspools or privy vaults, or any physical condition which is a breeder of disease and is unsanitary, without giving that fact the proper notoriety that would correct the disease or filth-breeder at once. It should make no difference in whose house or on whose premises the unsanitary condition exists, or in whose home the disease

is found. We all know of instances where a case of some infectious or contagious disease has been secreted and treated by the physician with no effort at quarantine whatever, because the case was in the house of the town mayor or one of the city "dads," or in some home other than the ordinary.

### The Curse of Gonorrhreal Infection

What doctor has not known of instance upon instance of a young wife, newly wed, who took with her to the altar and bridal chamber purity, cleanliness and noble devotion, and who within a few days after marriage comes to our office with complaint of painful micturition, awful burning "just when the water starts and just when it stops, doctor," and a discharge that stains her clothing, and so on? And for centuries, we, as physicians, have been covering up the fact that her trouble lay at the door of her newly wedded husband who, though demanding chastity and purity of womanhood at her hands, brought to her the filthy gonorrhreal virus from a white or may-

\*Read before the Green County (Mo.) Medical Society.

be even some negro wench, or God only knows from whence, and "thought he was cured," but now brings his pollution and prostituted self and pours its poison out into the potentialities and prospects of his own posterity.

Tens of thousands of just such cases are scattered all through our social world, and few of these women—very few indeed—realize the source of their trouble, while they wonder at the fact of their not becoming pregnant again. Hundreds, yes, thousands, of those pitiable victims become unsexed, every year, by salpingitis, pyosalpinx and cystic ovaries, the direct result of gonorrhreal infection, acquired from their husbands.

Stealing and pilfering from his wife in that way is as criminal and as much a theft as ever was committed by man on earth, and outraged womanhood bears it unwittingly. And we men smile as our daughters are being made infertile and denatured.

The M. D. of today is not a physician only but he is a sanitarian as well, and his mission as sanitarian is the much more important of the two because it has to do with the interests of the many, instead of the one or few. The people generally are beginning to look to our profession for the preservation of health as much as to restoration. While the physician does his duty along this line he may expect some censure and uncharitable compliments. Expected or not expected, however, they inevitably will be bestowed.

In this particular line of thought I want to direct your minds to the ignorance of the laity generally on sexual life.

#### **The Laity Opposed to the Discussion of Sexual Questions**

I am aware that the laity will, as a rule, hold up holy (?) hands in horror, and with false modesty and hypocritical blushings oft will exclaim: "Oh! you must not talk of those impure things nor think of mentioning them to our pure-minded children [though those children may be twelve or fifteen or even twenty years of age]. Why, they never even have dreamed of sexual things." Now, maybe they have not

"dreamed" of such matters—yet; but they have wondered, and talked, and discussed, and experimented in secret hours of and with that part of their physical makeup and peculiar sensations; and because of misinformation and noninformation, they oftentimes are injured physically, and God alone can tell how much injury the human race has endured and suffered because of the prevailing ignorance regarding the sexual function.

If the laity in general understood as much about the sexual makeup of themselves as they do of the other parts of their physical nature, there would not be one case of clap where there are now a hundred; there would not be one case of syphilis where now there are fifty; there would be not more than one case of a young woman suffering the torments of the damned, once every three to five weeks, with her menses, where now there are twenty-five; and there would not be one deformed, congenitally smitten babe born into this world where now there are ten.

If this change were to come about, we should not have so many jobs at healing, but that great and growing and God-ordained social life would become purified and the superstitions and sufferings and sexual sins of our race would move on and out before the doctors who will sit down and carefully explain how and what is expected of a man by a woman and of woman by the man, and then instruct the fathers and mothers in the knowledge they should impart to their children concerning their sexual nature.

Sentimentalism should not have any place at all in our thoughts—never! never!! when it conflicts with the inexorable, inevitable laws of nature.

#### **The Threefold Nature of Man**

We recognize that heredity, environment and education constitute the threefold nature or being of our makeup—physical, mental and moral; while sentiment is the child of culture which oftentimes is cultureless.

First of all, we recognize that during growth and before the realization of ma-

turity every living cell is actuated by two principles which are cardinal to every cell or collection of cells, i. e., action and nutrition. Without required nutriment the organism could not live, and that nutriment is obtained by the motility of the organism sufficient for its appropriating from the surrounding medium that which is necessary for its life. Then, with maturity, we see the organism developing the third fundamental faculty and function of its being, namely, furnishing a part of itself for another separate existence. Hence reproduction.

This coexisting trio which together constitute every kind of matured organism, including man, i. e., motion, nutrition and reproduction, issues forth into the world, and through all the ages no upraised hand has stifled either of these three nor has barred the more fully developed offspring or reproduced organism in any known domain except in that class of organisms known as human beings. While everywhere the unrestricted use of these three powers has gladly been conceded to all other organisms, we find through the past centuries a ban placed upon man in this respect.

#### I Ask, "Why"

It is a fact that we as gladly welcome and speak with ease of the mixing of pollen in a tasseled cornfield as we do of the little sprout where the corn is "coming up;" we are at ease discussing the inadvisability of having pie-melons and watermelons or squash and citrons growing close together in the field because they will mix and spoil the breed; yet, let anything pertaining to the sexual life of a human being be said, and immediately folks will cry out "Shame, shame," to even think of such a thing.

In the name of humanity, I ask—*Why?*

Now, as a matter of fact, we know that man, with his complex organization, is incapable of reproducing his kind alone, being dependent upon a like, or rather a complementary, organic body. Thus man becomes a social creature, because the third of this trio, reproduction, cannot be realized by either male or female alone. So, then,

the basic principle of society is the dependence of one upon the other for natural existence, while the function of reproduction is not absolutely necessary for the mere existence of the one individual body.

We must recognize that of the three elements, motion, nutrition and reproduction, the last is the spontaneous result of the first two, the natural result; and the perpetuation of the species is dependent upon reproduction. Thus the preservation of self through propagation, while not an absolute requisite for the maintenance of the individual life, is the greatest and supremest desire of the human being, and of all other organisms as well; and the function of reproduction is the supreme effort of the matured organism in the perpetuation of the species.

#### Our Adolescent Youths Improperly Instructed

Very much time and effort are spent in teaching young people how to conduct themselves in society, that they may make a good impression, and we well know how much stress and pains are manifested to bring about a desirable matrimonial union; but, pray, tell me how much instruction is given to these young men and women regarding the all-important question upon which will rest the physical well-being of future society. Why, bless you, for centuries past these couples have been led to the doors of the bridal chamber, without one iota of sensible teaching or information relative to their conduct within that sacred room.

I cry out aloud against this state of affairs, for it is criminal, utterly criminal. Think of our daughters having been left, for all these centuries, at the threshold of life's crucial period, restrained, hampered, taught to hang their head and be ashamed of the realization of what no one ever said was other than intended by our Creator.

There she stands, trembling, wondering, fearing. And, oh! how many disappointments to herself and to her husband because of the rotten, hellish beliefs and the practices thrown around us by so-called modesty but which should be called murder, and be-

cause of a sentiment which should be consigned to hell now and forever.

#### Medical Profession Has Been Culpable

Yet, lo, for these ages, with others, we doctors have bowed to this mock modesty and prudish blushing, and have sacrificed thousands upon thousands of what would have been happy homes in a blissful union, for ruined health and complaining companionship—all because of this criminal ignorance of sexual things. And shall I not say, the doctor is to blame, when we hold the power absolutely in our hands, to put the broad sunlight of intelligent instruction into the shade-drawn darkened window of the summertime of youth?

You know as well as I that the reason why there is practically no literature on this subject is because men have been afraid to picture the actual truth concerning the real facts of sexual life or function. Here and there has been seen an effort along this line, born of mercenary motives, or a book by someone not capable of writing on the subject, which more often have caused apprehension and uneasiness, unnecessary solicitude and misery, rather than good. I have in my library two such books I bought when a young man before studying medicine, which were written by preachers. Time and again both the laity and our profession are confronted by books that contain libel after libel and in which normal physiological conditions are described, and even pictured, as pathological.

#### High Time to Inform the Young

Is it not time, gentlemen, that we should be as sensible about our children and our neighbors' children as we are about corn and hogs? And though there be some hard kicking by some saintly (outwardly) folks, why should we as doctors not compel the people in every neighborhood where we live to be as sensible about their children in talking with them concerning themselves and their bodies as they are about Plymouth-rock chickens or some certain kind of popcorn?

Time upon time have women told me that they had never had a word spoken to

them about their monthly period till after they had menstruated the first time, and then very little was said. I once knew a girl who when menstruating the first time at the age of fifteen and a half years, thinking that something awful must be the matter with herself, secretly washed herself with ice-cold water, the bad effects of which she will carry with her to the grave. I have known boys who at play or work would injure a testicle seriously and, because of impressions that had been fixed in their mind by teaching and environment were ashamed to speak of it to their father or mother, the lack of medical attention costing them the life of the testicle. Gentlemen, nobody can stand up and say but that tens of thousands of these and similar cases are to be found in every part of the world. And it is criminal.

We recognize that the desires of every human being are threefold, namely, those which are either physical or mental, or these two combined. Physical desires are illustrated by our longing for air, food, light, etc. Mental desires are acquired as a result of environment, education or training, such as enthusiasm, ambition, etc. Lastly, the desire or longing which is both physical and mental is the one that we call sexual.

#### Why Continue to Foster this Ignorance?

Now, as to the last-named, can anyone tell me why we should have definite, positive knowledge and instruction in the first two and ignore the third? Why should we teach our children relative to their own physical desire or lead them out into anticipations and purposes mentally and put a blind before their eyes and say, "Shame," if they ever manifest any desire for knowledge concerning the sensations and wonder of the desire resulting from the union of physical and mental forces. Why should we, as doctors, permit the fostering of this ignorance concerning sexual things, when the knowledge concerning the physical and mental desires and gratifications of the same have to do only with the individual concerned? But, the proper, sensible, intelligent knowledge of the organization of sexual desires has to

do with the great social life, that which, as we said before, lies at the very base of our most sacred institution, the home.

When the newborn babe opens its eyes to the things of this world all the desires it has are physical. No will-power at all governs its actions. Jacobi tells us that "for a short time after birth the conducting fibers between the undeveloped brain and pyramidal fibers of the cord perform no function." It takes the psycho-motor centers at least a month to exhibit the first signs of existence. Thereafter the brain develops very rapidly but not uniformly. A little later we find developing what commonly are termed the general and spe-

cial senses. Through the growing power of the nervous system we gradually come to a knowledge of the different parts and organs of our body, because of the sensations resulting from stimulation of certain centers.

Now, in a general sense, we have the desire to evacuate the bowels and the general muscular tingling of power, or of hunger, or of tired feeling. Then the special senses are commonly classed as five.

Generally speaking, more marked promptness and ease of cerebration, or the complete cycle of thought-activity, results from force of habit, that is, from repeated exercise of certain centers along a given line. One must recognize that every sensation of neces-

sity makes its impress upon the sensitive mind-plate and it becomes in a very large sense indelibly fixed. Hence the ordinary teaching that growing children get, as a rule, concerning their sexual organs and senses

can but impress them in a manner that is unfair, dishonest, deceptive, and calculated to make them deceivers. Liars, and hunters for knowledge in secret.

Gentlemen, that is criminal, if anything on earth is criminal. How many of us, as we grew up and while we were yet boys in kneepants, have not deceived our mothers and kept from them facts of our investigations in some secret place with other boys and perhaps with some girl about our

own age? Do you remember some such conversation between your good mother and yourself happening these many years ago: "Johnnie, I haven't seen or heard you and Mary for a good while; where have you been?" "Oh! we've been to the barn and around." "And what have you been doing?" "Oh! we've been playing." But you did not explain just what you had been playing at. How many of you do not recall such scenes?

Who of us have not marked the peculiar expression in the face and manner of the boy as his voice begins to change and in his entire presence we see foreshadowed the coming powers of manhood. Who of



DR. D. E. STANDARD

us have not noted with keen perception the change in pose and act and everything of the opening bud of the flower of fidelity as the Great Virgin puts her arms around the girl-child, beholding her changed, with developing breasts and rounding limbs? She goes forth into a new world, blushing and stumbling and wondering, conscious of new mysterious sensations that she cannot stifle—sensations and longings as natural and instinctive as the desire to eat when hungry or to slumber at the end of day—and she walks falteringly out, walks with faltering foot toward that perilous pinnacle of matured womanhood.

#### Pity the Man-Boy, the Woman-Girl

There they stand, the man-boy and the woman-girl, with life before them, realizing the fast-developing power of the magnet of sex as it draws them they know not how, they know not whither. And why do they not understand, why are this man and this woman to-be thus mystified? Let me tell you.

During all the centuries of the past, instead of nurturing and fostering a rational knowledge of sex, as we do in the case of the other faculties, socalled civilization, and socalled sentimentalism, and socalled morality demand its entire suppression, and everybody religiously refrains from any reference to the subject. And all this because some cachectic, bloodless, abnormal individuals have persistently cried out: "For heaven's sake, don't say anything to them about sexual matters. Don't talk about such things—it makes one feel so ashamed." And so our youth, with its vibrant virility, with its exuberant enthusiasm, with its powers and possibilities, and its ideals of purity, plunges longingly into our modern social world, into that great sea of experience, only to be stung by sin and tinged with taint, and tormented by poisons in the blood. Then, as a result of this ignorance of sexual things, our boys become the pitiable vic-

tims and the horrid dispensers of the virus of gonorrhea and of syphilis, and thousands of homes are "blessed" (or cursed) with just the one child, which, if not permeated with disease and puny, is an object to be pitied because of the hard place it may have to stand in as an only child, petted, and feasted, and humored, and ruined oftentimes in disposition and temperament.

#### Gonorrhea the Principal Cause of Race-Suicide

There is no longer any doubt whatever but that gonorrhea is, by all odds, the most active cause of depopulation, or socalled race-suicide; while all modern writers agree that this infection is the chief of all causes in the inflammatory diseases peculiar to woman, and surgery of the female pelvis reveals the startling fact that 90 percent of it is due to gonorrhreal invasion. Hundreds and hundreds of our women have had one or both ovaries removed because of the diseased condition due to gonococci, but yet they are ignorant of the real facts.

Gentlemen, while these diseases peculiar to the sexual organs sweep curse-laden over generation after generation, reaping their hideous harvest in our homes, spreading blight and pain and sorrow, and while our surgeons are removing ovaries, by the thousands, made cystic by gonorrhea, and when blear-eyed, weazened-faced hunchbacks and distorted babes are pushed into our social world, crippled and cursed by syphilitic ancestry, we, the doctors, the conservators of human life and well-being, are doing nothing to stem the tide.

God Almighty and the angels in heaven must feel shamed at the sight, and in the name of our common humanity I declare it is high time for us, as doctors, to do our duty and drive the rank, rotten, silliness-born ignorance about things sexual from our midst.

Will we do it? Will we?



# Therapeutic Properties of Verbena Hastata

*A Critical Investigation into Its True Sphere of Usefulness*

**By J. M. FRENCH, M. D., Milford, Massachusetts**

**EDITORIAL NOTE.**—*Dr. French, a well-known contributor to "Clinical Medicine," gives here an interesting account of his careful studies, extending over a number of years, on the action of and indications for verbena hastata, which he has found to be of value in certain forms of epilepsy. The doctor's splendid investigations afford another evidence of the good work which a practitioner in active general practice can do. Some of the most important discoveries have been made by such, and Dr. French's researches should stimulate others to go and do likewise.*

IT is now a little more than eight years ago that I began to use verbena hastata in my own practice, after having, for several years previous, studied its action as reported by others in medical literature. I have not employed it in a large number of cases, but I have endeavored to observe its action carefully in every instance. I have also collected all the reports which have been printed in medical books and journals that had any bearing upon the therapeutics of this drug, including some which I have been able to secure for publication from users of the drug. For the past two years I have endeavored, through the columns of several medical journals, to secure reports sufficient to constitute a collective investigation concerning the same; but, I regret to say, the number of those who have aided in this direction is but small. Nevertheless, I have collected and summarized all that I have been able to obtain in these several ways, in the hope of being able to present the most important facts which are known to the medical profession concerning this drug.

Several years ago I published a summary of what I then knew concerning verbena, which was reprinted in a number of journals. In comparing this statement with my present knowledge of the subject, I realize that I have not added many points of importance to what was then stated, nor have I made many radical modifications of my opinions as to its uses. Therefore this paper, as compared with that one, will contain many repetitions, together with

some unimportant modifications, besides a few slight additions. This means that whatever value this paper may have rests upon a wider study of the observations of others and some years of additional personal experience in its use, which have in the main confirmed my earlier experiences and conclusions, with slight modifications and additions.

## **Its Range Is Limited, Although Formerly Recommended for Many Disorders**

Let me say at the outset that verbena is not a remedy of great power or wide applicability. Only in comparatively few conditions is its use now recommended. For all of the older uses we have at hand today many other and better remedies. If it shall be found worthy of a place in the *materia medica* of the modern and progressive physician, it must be upon the ground that it is a better remedy than any other which we possess, in certain definite conditions of disease. This I believe to be the case, even though the conditions are not the most frequently met with. The physiological action of verbena is not marked. Indeed, if we consider the physiological action of a drug to be its poisonous action, I have not found it to possess any such action in the doses in which I have employed it.

*Verbena hastata belongs to the class of symptom-medicines, acting upon the healthy as well as the diseased, and manifesting its characteristic symptoms at a single dose.*

Up to a very recent date we owe most of our knowledge of its properties to the elec-

tics and other herbalists. Felter and Lloyd ("American Dispensatory") consider that it possesses tonic, emetic, expectorant, and sudorific properties. Scudder ("Specific Medication") says that it relieves irritation of the stomach and intestinal canal, and promotes digestion and secretion. Paine recommends it as producing good results in rheumatism, gout, and piles. Griffin uses it, in the form of an infusion, as a remedy in ivy poisoning. Day advocates it for the cure of intermittent and remittent fever, and also as a remedy in the treatment of the opium habit. Boericke ("Manual of Homeopathic Materia Medica") says that it affects the skin, promotes the absorption of blood, and allays pain in bruises; is useful in vesicular erysipelas, passive congestions, and intermittent fevers; is one of the remedies for poison-oak; is useful in epilepsy, insomnia, and mental exhaustion. Piffard recommends a tincture of the leaves and fresh plant for alopecia, used locally; while internally he uses it for swollen glands, and in severe headaches with sharp, ringing pains.

At the present time, however, and so far as I have any knowledge, the most of these uses are obsolete. We have many better remedies as a stomachic tonic. We do not need it in rheumatism, gout, or piles. No one now thinks of employing it in fevers, or as a cure for the opium habit. We do not often hear of its use in ivy poisoning. Only in the last clause of Boericke's statement do we get any hint of the uses for which the present writer has employed it, namely, epilepsy, insomnia, and mental exhaustion.

#### The Nervous System Its Only Sphere of Action

This brings us to the second point, its sphere of action. So far as I am able to judge from my own use of it or from what I have learned of its use by others, its only important sphere of action, at least so far as its value as a medicine is concerned, is the nervous system. Whatever other actions it may have are of secondary and very slight importance.

As to the nature of its action, I am somewhat in doubt whether to class it as a nerve

tonic or sedative, but decide upon the former, since its predominant effects are to strengthen and improve the action of the nervous system. It builds up instead of depressing, strengthens instead of weakening. Perhaps it might be more properly classed as an anti-spasmodic, since it allays excitement, relieves irritability, and promotes normal action of the nervous system.

#### Certain Forms of Epilepsy Its Particular Field

The particular conditions of disease which verbena is found most often to relieve are found in some cases of epilepsy. I make the statement in this form, because I wish to guard against the idea that verbena is a cure for epilepsy, or even a remedy in every case of epilepsy. The most which I claim, and the main fact of which I have been convinced, is that it is of value in certain cases and conditions of epilepsy; while in other cases and conditions the reverse is true. The object of my study has been to determine, and the object of this paper is to record in so far as I have been able to determine, those cases and conditions in which it is of value, and those in which the reverse is true.

Epilepsy is a disease so serious in its nature, so intractable to the ordinary forms of treatment, and so generally given over as hopeless, that any drug or method which presents any reasonable evidence of being beneficial, even in a small proportion of cases, is entitled to careful consideration and thorough trial.

Hessel finds verbena, even in small doses, to be of benefit in those conditions generally included under the head of nervousness. In the same line I have found, in cases of epilepsy, that its first noticeable and characteristic effect is that *it brightens up the patients' mental powers and gives them a more cheerful aspect*. Thus, of one girl, soon after she began the use of verbena, her mother reported to me that she was brighter and more cheerful than she had been under the influence of the medicine she had previously been taking, which evidently contained a bromide. She was readier to speak and

quicker to answer than formerly; and whereas before she never saw anything to do to help her mother, now she found many things to do, and that without being asked.

**Controls Certain Forms of Nervous Depression**

This is clearly the effect of a nerve tonic, and is in marked contrast to that of bromides, which have almost always been used in these cases before verbena is tried. It indicates other and broader uses for the drug, and leads to the suggestion that verbena may be the remedy, fundamentally, not indeed for epilepsy or any other disease as a whole, but rather *for certain conditions of nervous depression*, weakness, irritation, and spasm which are found in many cases not only of epilepsy but of a considerable class of nervous diseases.

In favorable cases verbena does not usually stop the paroxysms all at once, but rather produces a general improvement, rendering the attacks lighter and the intervals between them longer, and finally, in a certain proportion of cases, permanently preventing their recurrence.

It is claimed by some that the extract of verbena has a decidedly favorable effect upon the constipation so often found in epileptic patients, which it is said to relieve without any drastic action. Less of this action is seen when the concentration, verbenin,

is employed, although this does show some slight laxative effect.

If the effect of the remedy is favorable, lessening the frequency and severity of the epileptic paroxysms and improving the general health, its administration should be *continued for an indefinite time*. No patient should be encouraged to believe that a cure has been effected—that is, a permanent cure

—until at least two years have elapsed since the last manifestation of the disease.

All experience shows that it is a comparatively easy matter to check the convulsions for a period of several months, or sometimes even years, while yet the dreaded symptoms will return at a later period. Even two years is far from being a period conclusive of permanent cure. Indeed, in a large proportion of cases, and cases which are unquestionably benefited by treatment, exper-

ience will soon convince the observant physician that no period of freedom from convulsions is proof positive against their recurrence, at least in cases of long standing. Therefore, when there are occasional relapses, even though the intervals be years, *the rule should be to continue the treatment during life*. That the use of verbena hastata in this manner is without danger, is shown by a case in my own practice, where large doses have been taken almost without interruption for more than eight years, with evident benefit



DR. J. M. FRENCH

and without any unpleasant results. In this instance the patient is satisfied to continue the treatment during life.

#### General Indications

The cases which are most likely to be benefited by verbena are of three classes:

1. The recent cases, in which the *status epilepticus* is not fully developed.

2. The comparatively mild ones, in which the convulsions do not occur with extreme frequency and are not exceptionally severe.

3. Those in which the mental faculties are not greatly impaired.

In short, they are those cases which might naturally be looked upon as curable, or at least as offering a hope of cure. In the old and severe cases, where the spasms are extremely frequent and the mind is greatly affected, and where partial relief is the most that can be hoped for, there are other remedies of greater value.

There is another indication for the use of verbena which has been of much practical help to me in selecting the cases which are likely to be benefited by it, and that is where previous experience has shown that the *bromides act unfavorably*. In some cases bromides plainly make the patient worse; in others they simply do no good; and in still others the secondary and incidental effects are decidedly unpleasant. In all of these cases I have come to look with confidence for good results from the use of verbena hastata; while on the contrary, if much benefit has been derived from the bromides, and the secondary action was not unpleasant, I have come to doubt the beneficial action of the former remedy.

It has also been said by some to be of especial value in cases of menstrual epilepsy, or epilepsy dependent upon the establishment of menstruation or of derangement of menstruation. I give this statement on the authority of several writers, but my own experience has not been sufficient in these cases to satisfy me one way or the other.

Remember that there is a small proportion of cases in which the action of verbena is evidently injurious, making the patients

worse rather than better. When this fact is established, its use should be abandoned. Do not let any theoretical notions of what ought to be prevent you from stopping it at once. If, as is very apt to be the case, these are the ones that are helped by the bromides, return to them at once.

#### Apparent Connection with Visceral Derangement

Professor G. H. French of Carbondale, Illinois, reports, from his personal experience, that verbena is of most value in those cases of epilepsy in which the exciting cause is visceral rather than cerebral. This does not differ much in essence from what I have already said in substance, that it is most helpful where the cause can be removed, and the convolution-center has not become hopelessly affected. A case in which the spasm is brought on by constipation or an overloaded stomach is much more hopeful than one in which it comes on merely because the convolution-center is diseased without any apparent exciting cause.

#### Preparations and Dosage

The herb itself may be used in the form of a decoction or tea; but this is rarely done in these days of elegant pharmacy. It would no doubt be very difficult to induce the ordinary patient to take the remedy in the form of infusion long enough to effect a cure.

The fluid extract may be employed in doses of from 10 to 60 minims. Concerning this preparation, John Albert Burnett (*Journal of Therapeutics and Dietetics*) has this to say:

"There is one thing to be said against the use of verbena hastata, and that is its horrible taste. Most people consider it very bad to take, and so it is. I have never found a worse dose, according to my taste, than half a teaspoonful of this remedy, and I do not think I could take such a dose very often. It could be made into an extract, as other remedies are, or taken in capsules, or made into pills and used that way; or its taste could be covered to some extent by making it into a syrup, similar to the aromatic syrup of

rhubarb, or an aromatic fluid extract, like the aromatic fluid extract of cascara sagrada. One thing is sure, not many people would take the common fluid extract and continue its use very long."

On the other hand, Dr. H. D. Fair of Muncie, Indiana, in a personal letter to the writer, declares that he has secured the best results from a fluid extract made by Wm. S. Merrill & Co., of Cincinnati, which he considers much better than the concentration he gave a trial.

I judge that the solid extract is but little used, as I have seen no reports of its use and do not find it listed by any manufacturing drug firm.

The concentration, which is known as verbenin and is manufactured by The Abbott Alkaloidal Company of Chicago, is the form which I have used in every instance, and it has served my purpose so well that I have not sought for other preparations. It is prepared in the form of small tablets, each containing 1-3 of a grain, and representing the medicinal properties of 10 grains of the crude drug. This is not unpleasant to take and is well borne by patients for an indefinite length of time.

Should the Lloyds or Merrill prepare it in the form of the specific medicine, this can then be tried out in comparison with the other forms.

There is no absolute dose, the only object being to secure the effect. My own custom has been to begin, for adults, with one tablet of the concentration before each meal, and increase one tablet each day (Note: not one each dose) until the desired effects are secured or I have become convinced that it is not the indicated remedy. This is usually secured with a dose of four to six tablets taken before each meal; but there need be no hesi-

tation in going beyond this limit if this appears necessary.

#### Summary

1. Verbena is not a remedy of the greatest power or widest applicability, but is of special value in certain definite conditions of disease which are not readily controlled by the usual medication.

2. It belongs to the class of symptom-remedies, and its most important action is that of an antispasmodic and nerve tonic.

3. It improves the condition of the nervous system, brightening up the patient's mental powers, and giving him a more cheerful aspect.

4. It is of great value in certain cases of epilepsy, while in others it is of no value whatever, and may even prove injurious.

5. In favorable cases it does not usually stop the convulsions at once, but produces a gradual improvement, rendering the attacks lighter and the intervals longer, and in some cases permanently preventing recurrences.

6. It is of most value in mild and recent cases, those in which the mental faculties are not greatly impaired, and those in which the convulsive seizures are dependent upon some cause outside the brain.

7. In my experience, I have found verbena to be favorable in proportion as the action of the bromides was unfavorable.

8. It is said to be of especial value in cases of menstrual epilepsy, and in petit-mal.

9. When the action is favorable, and yet the convulsive seizures continue to recur occasionally, its use should be continued during life.

10. The most convenient and agreeable form is the concentration, verbenin, which may be given in increasing doses up to six grains a day, or even more.



# Cocaine as a Local Anesthetic

By BENJAMIN H. BREAKSTONE, B. S., M. D., Chicago, Illinois

*EDITORIAL NOTE.—The author, who is professor of surgery in one of the medical colleges in Chicago, describes in a clear and simple manner the various modes of administration of cocaine for the purpose of local anesthesia. Our readers cannot but benefit from the experience and advice of Dr. Breakstone.*

In my surgical practice I have used cocaine almost exclusively for inducing local anesthesia and I have never had a single bad result follow, as regards constitutional symptoms. In my early experience, however, I have encountered some local bad effects, such as gangrene, hematoma, etc. These bad effects, however, I have found could be entirely remedied by finding out the cause and removing it. It can be stated now that the complications arising in operations performed with a local anesthetic are far less than those performed under general anesthesia.

## How to Avoid Complications

In the first place, unpleasant results may be avoided by using a 2-percent solution made with *sterile water*, and *freshly prepared* each day before using, we do away entirely with the constitutional symptoms, such as vomiting, headache, syncope, etc.

Cocaine is a complex organic compound which easily undergoes decomposition and is also easily affected by microbes, especially in solution, and therefore, to be safe, the solution must be freshly prepared in sterile water. Further, it is also easily decomposed by heat, and therefore the solution must never be boiled or the cocaine will be chemically broken up. It must therefore be simply pasteurized ( $157^{\circ}$  F.). It must never be brought to a heat of more than  $180^{\circ}$  F. If kept in a cool, dark place, the solution may be kept for a week, but never longer than ten days in a room of ordinary temperature.

There is a preparation, codrenin, which has this advantage over cocaine that it may be kept for months without decomposition. It is a mixture of cocaine, chloretoe, suprarenal extract and normal salt solution,

and it may be that for the general practitioner it might be well to use this solution, although for myself I prefer to know just what I am using and so have the solution made as I need it.

Secondly, if we *pay strict attention to asepsis*, we shall do away entirely with the local complications, such as infection, gangrene, etc. The percentage of cases of infection following operations performed with cocaine anesthesia is far less than those performed under a general anesthetic, for the reason that there are not the gastrointestinal, respiratory or urinary disturbances which so very frequently follow the use of a general anesthetic, and thus lower the vitality of the patient. Therefore, wounds produced by operations performed under cocaine anesthesia heal more kindly and more rapidly than wounds produced by operations under a general anesthetic, because the general system does not suffer and all the traumatism is purely local.

Third, because cocaine is so readily decomposed and infected, it should *never be used in an infected area*. I prefer ethyl chloride for superficial abscesses and the like, but if cocaine is used, it should be used outside of the infected area, and *if the infection is a chancroidal one* (streptobacillus of Ducrey), then the cocaine should be injected quite a distance away.

Fourth, to prevent the absorption of the cocaine solution, an Esmarch constrictor (in the shape of an ordinary rubber band) should be used whenever possible, and when the operation is completed, before applying the dressings, the wound should be made to bleed freely, so that as much of the cocaine solution as possible may exude with the blood, thus lessening the chances for subsequent edema, and also to wash away any

infected material that might by chance have been introduced into the wound.

*Schleich's solution*, which is cocaine plus morphine and sodium chloride, was devised with the idea of minimizing the constitutional symptoms occasionally following the absorption of large quantities of cocaine. I have used both Schleich's solution and a 2-percent solution of cocaine, and I do not find that Schleich's solution possesses any advantages. Of course, formerly, when stronger and less aseptic solutions of cocaine were used, Schleich's solution did have its advantages, but now that we practice asepsis, not only as to the solution but with regard to the preparation of the field of operation and the instruments, dressings and the surgeon's hands, the results obtained by the use of a 2-percent solution of cocaine for local anesthesia are perfectly satisfactory.

### III Effects from General Anesthesia

Many bad results have been attributed to cocaine merely for the reason that they occurred after employing it. No attempt has been made to explain these bad results in any other way, especially by surgeons who operate mostly in hospitals, but if carefully analyzed, it will be found that the untoward effects following the use of cocaine in those cases were merely incidental. There is no more reason to have ill results follow operations performed under a local anesthetic than to have ill effects follow operations under a general anesthetic. Indeed, I will repeat that the percentage of ill results following operations performed under a local anesthesia is far less than the ill results following operations performed under a general anesthetic.

The preparation which I use is cocaine hydrochloride. I have tried eucaine and betaeucaine with no better result, and, I think, with less anesthesia than solutions of cocaine hydrochloride itself produced; and wherever I speak of cocaine, in this book, I mean cocaine hydrochloride.

### The Modus Operandi

The solution should be injected, as a rule, along the line of proposed incision, so far

as possible. In infected areas, however, it should be injected around the area of infection. If the infection is virulent, such as a chancroid, etc., the cocaine should be injected very far from the infected area. In some cases, such as in circumcision, ingrown toe-nail, etc., the injection is introduced around the base of the member or growth. The method of introducing the solution for these particular operations will be fully described in their appropriate places.

The injection may be made absolutely painless by first spraying the point of the first entrance of the hypodermic needle with ethyl chloride. After the air is expelled from the hypodermic syringe, the needle should be introduced right beneath the epidermis as far along the proposed line of incision as possible, then the solution should be gradually expelled from the syringe into the skin, as the needle is being withdrawn. An area of edema, also known as wheals, results from this injection. To introduce the next injection, the needle should be introduced at the forward end of this wheal so that it may enter an already anesthetized area.

There should be as many injections introduced as are necessary to anesthetize completely the line of proposed incision; that is to say, that the entire line of the proposed incision (except in the special cases to which I have referred above) shall be an area of edema. If deeper areas are to be anesthetized, it can be done after the incision is made. Then the cocaine can be applied with an applicator saturated with the solution as the dissection is made more deeply.

The operation should not begin for at least fifteen minutes after the injection is completed, and it is better to wait twenty or even thirty minutes. I usually prepare the patient and make the injection, then, while waiting for the cocaine to take effect, I prepare instruments and dressings so as to lose no time. The anesthetic effect usually lasts from twenty-five minutes to an hour and a half, and in some cases, especially in areas where an Esmarch bandage can be used, it may last for several hours.

However, if the operation is to be a prolonged one, more cocaine may be injected as needed. The quantity used does not matter very much. I have used as much as one ounce of the solution in a single operation without any ill effect resulting. Usually 1 or 2 drams of the 2-percent solution are sufficient, while very seldom more than 3 drams are necessary.

#### Some Special Advice

All during the operation it is advisable to keep up a conversation with the patient so as to detract his mind from what is being done, as nervous patients are continually anticipating ill results, owing to the fact that they have heard and read so much about these things. However, a sound, reasonable patient will have the operation performed without a word, and will leave the table and

go home as if nothing had happened. Still, in a few cases, after the operation is over, they may have some pain, and for these patients bromides are indicated for the first twelve hours following the operation.

Local anesthesia may be used in any patient regardless of the condition of the heart, lungs or kidneys, and may be used at any age. In children it may be used at such an early age as the patient is able to be under control and will not fear the introduction of the hypodermic needle. As a rule it is preferred to have one of the child's relatives, in whom the child has perfect confidence, to take charge of him, so that the child may be under full mental control. At one of my clinics at the Jenner Medical College I circumcised, under local anesthesia, a child three and one-half years of age without the least trouble.

## The Nez Percés Indians

By CHARLES STUART MOODY, M. D., Sandpoint, Idaho

*EDITORIAL NOTE.—This is a further paper by Dr. Moody on his interesting experience among the Nez Percés Indians. In it the Doctor describes in vivid language how he found the medal which, many years ago, had been given by Captain Lewis to the Indians in token of amity and friendship.*

#### II. FINDING THE MEDAL

**I**N the preceding chapter I mentioned old Hale's speaking, at various times, of a medal given the Nez Percés by Captain Lewis when he made the treaty with them on the island where the exploration party first camped. This medal was so esteemed by those Indians and was held by them in such veneration that it really became an integral part of their association with the white people. It constituted the link which bound the past with the present.

#### The Medal a Token of Friendship

That bit of molded metal was presented to the Indians as a token of amity, a symbol of friendship between the two races. Captain Lewis told the chief to whom he presented it that it should be a talisman for the protection

of his people and any white man who saw it would be glad to clasp in brotherly love the hand of the Indian holding it, even as were clasped the two hands shown on the medal. This was only partly true; it was true insofar as the citizens of the United States were concerned, but not for the subjects of Great Britain with whom the Indians afterward came in contact in the persons of the Hudson Bay trappers who entered the country early in the last century.

The token was accepted and preserved by them, however, and made use of in the spirit in which it was given, and no doubt it did, many times, subserve the purpose intended. Twisted-Hair gave the Lewis peace-medal to his son, and he in turn passed it down to his posterity. Then, for several years, it was lost sight of. No one seemed to know

what had become of it. There were many Indians who knew, as I afterward learned, but they were loth to reveal its location. For many years I tried to get track of it in vain.

#### Medal Became a Sacred Totem

Finally I came to the conclusion that it had been laid away among the treasures of some of the leading families as a sort of "wy-ya-kim," or totem, and as in time it had grown sacred, they would and could not speak of it. It may be stated here that it is a tenet of their religion, as I shall have occasion later to explain, not to talk about anything that is sacred in character, as, for instance, their "wy-ya-kim" (that is, the totem, or sacred badge, usually an animal or a bird) adopted as their guardian spirit.

Old Hale would talk about the medal, but every time I asked him where it was he would become uncommunicative and reply, "*Wato imchesa*" (I do not know). I was convinced that he did know, but wild horses would not drag the information from him unless he chose to reveal it.

When we first came among the Indians, I met an intelligent half-blood, and between us there soon sprang up a lasting friendship. This man acted as my interpreter until I had acquired a working knowledge of the language. One day, after I had been among them for several years, I said to him:

#### The First Clue

"Charley, there is in existence among your people, somewhere, a medal given to them by Lewis and Clark. That medal has outlived its period of usefulness to your people but is of inestimable value to the whites. You either know where it is or can find out. I want it. Of course I know it would never do to ask the old men for it; they would not understand. But with you it is different; you will understand how it is. Now, if you know where it is, tell me. If you do not know, find out."

"I do not know," was his reply. "Seltish wore it when I was small, but I have not seen it since Seltish died."

"When did he die?"

"That was many years ago. He lived with Natskin, and he was buried in Natskin's orchard when he died."

I could scarcely conceal my elation. Inadvertently Charley had revealed the secret the Indians had kept so closely all those years. Or did he take that means of telling me? I have sometimes thought so.

Not long after the above conversation I took occasion to visit the tepee of my friend



Nez Percés type. Note manner of wearing hair

Natskin and while there walked through his orchard. Sure enough, near one corner of the same, but annoyingly near to the log house and tepee in which the family lived, lay a lowly mound beneath which slumbered one of the departed chiefs of the people, and I had no doubt that on his breast reposed the intrinsically worthless piece of metal, but which, could I but lay hands upon it, would be, to me, beyond price.

To give you an idea of the naturally secretive disposition of the Indian, I will recount a conversation held with Natskin that day. We were walking in the orchard and I had been telling him something of how to rid his apple trees of insect-pests. Gradually I steered him around to where the grave lay. Now, he could have had no means of



Grass tepee, now very rare

knowing that I even suspected the presence of the medal in that grave, or much less that I had covetous thoughts about the same, yet when I asked him, "Natskin, whose grave is that?" he replied, "*Pas ke nox pinmix*" (one who is asleep).

That was all. I knew him well enough to know that he did not care to continue the conversation, and should I insist upon it his answers would all be equally evasive. For some perfectly satisfactory Indian reason he did not care to disclose the identity of the occupant of that grave.

#### Difficulty of Securing the Prize

A stranger, not familiar with conditions, would naturally suppose that knowing for

almost a certainty that the coveted article was in the grave, the recovery of it would be an easy matter. But such an assumption on the part of the stranger would argue, among other things, that he did not know the vociferous qualities of the average Indian canine. These dogs, direct descendants of the coyote, are possessed of the most strident and penetrating voices of any domestic animals of my acquaintance. They howl in season and out of season, day and night, without let-up. One cannot approach an Indian encampment without being assailed by hundreds of them in chorus. To approach



A young Nez Percé chief. The flag he is holding was given his grandfather by early explorers

that grave with resurrectional designs on the slumbering chief were to court prompt discovery and consequent enmity of every Indian on the reservation. No, some other plan must be thought out.

It took several years for the proper psychological moment to arrive. I bided my time with as stoical patience as might any Indian himself. Hundreds of times I passed the

corner of the orchard and looked longingly at that grass-covered mound. Never could I catch the family and the dogs all away at the same time.

Some philosopher has said, "All things come to him who waits." I waited. One spring Natskin announced that he and his were going that summer to visit with their cousins, the Flatheads. I question whether there was a person on that reservation who greeted that announcement with the same elation that I did, and it was with great interest that I assisted my worthy aboriginal friend in getting ready for his pilgrimage to the land of the Flatheads. Spring passed and summer came, but still the Natskin family tarried beneath their own vine and fig tree. But they were only waiting to attend the Fourth of July festivities at Lapwai, after which they could begin their trip. So, when on the 6th of July the Indians came strung back from their celebration Natskin made ready for his departure.

#### The Resurrectional Expedition

As the rearmost dog of the departing procession of men, women, children and dogs faded from sight around the point of the hill above the tepee, one might have detected a lanky individual armed with a brand-new shovel and a grain sack on his back legging it up the trail in the direction of the deserted cabin. That lanky individual bore a striking resemblance to photographs of Dr. Charles Stuart Moody, and I strongly suspect there was some solid excuse for the similitude.

In fifteen minutes I was on the spot desecrating the grave. The earth was soft and it required only a few minutes to reach the last resting place of the old chief. It may seem singular to persons unacquainted with the preservative qualities of the dry earth of the West when I state that the body, when exposed, was in as nearly perfect condition (although it had lain there twenty years) as when it was first deposited in the grave. It was swathed in heavy blankets which it required some effort to remove.

#### Finding the Coveted Medal

My search was rewarded by finding the medal, suspended by a buckskin thong,



Family in front of tepee

resting upon the breast of the body just above his totem. To sever the thong, secure the medal and shovel the earth back upon the body was but the task of a few minutes and I was on my way hastening down to the river to wash my treasure.

The medal was of some white composition metal about four inches in diameter. Upon one side was a vignette of President Jefferson, surrounded by the inscription, "Thos. Jefferson, President of the United States, 1803." Upon the reverse side two clasped hands, an Indian's and a white man's, surmounted by a peace-pipe and a tomahawk, with the legend, "For Peace and Friendship."



A typical summer Indian (Nez Percés) encampment

I am not given to visions and dreams, but as I held that bit of metal a scene of the past swept o'er me. I saw an island in a wide river, with Indian tepees scattered over it; I saw the red men clustered about a few whites listening to the words that fell from the lips of one of them; I heard the eager tokens of assent as the savages grasped the full import of the speech; I saw their dark faces light up with pleasure as the white man unfolded bright cloths, a braided coat, gaudy trinkets and things dear to the savage heart, and present them to the leading men; I saw the proud chief of the entwined locks stoop his head and receive from the white man a talismanic bit of coinage; I heard him promise fealty and friendship to the Great Father whose face appeared on the medal; I saw the strangers depart on their way to the western ocean.

Time ran on and the chief grew old, his steps moved haltingly toward the Land Beyond; I saw him call his son to his bedside and transfer the token to him; I heard him tell how it had been obtained and what it was to signify; I saw the son wear it all through the period of border settlement; and I saw it sink to sleep with him when he, too, joined the shades. These people no longer had need of that talisman, for by now there was no further need for its protective influence. Their tribe was broken up and dispersed, and the children of the men who gave the medal had broken faith with their red allies—they had taken the Indian's land,

and it was mete that the token should hide its face in very shame. And so it was hid, no longer to offend their eyes. There ended the dream.

#### History of a Second Nez Perces Medal

It may be of interest to trace the history of another medal presented to the Nez Percés by the explorers.

Upon the return journey the Clark and Lewis party reached Colter's (now Potlatch) River on May 5, 1806. There they fell in with an under-chief who, from a peculiarity in the alæ of his nose, was named Cutnose. This dignitary impressed the travelers with the fact that he was "big medicine" and as much entitled to consideration as was Twisted-Hair; which, by the way, was a fact, for neither of them were chiefs in the full sense.

Captain Lewis was anxious to propitiate the Nez Percés in every way possible. He saw that should emigration ever pour into the country it would be over the same trail traveled by the expedition. The Nez Percés, holding possession of the western approach to the country, could make things decidedly unpleasant for the settlers should they so choose. Therefore, when he of the slit nasal appendage urged his claims to consideration, the Captain did not feel inclined to argue the matter. The supposed chief was given a medal, but of a smaller mintage than that given to Twisted-Hair. It was of copper but bore practically the same inscription.

Cutnose wore it throughout his life and it was buried with him.

In 1896, while the Northern Pacific was building up the Kooskia region, headquarters were established at the confluence of Potlatch with the Kooskia River. This was where the Indian chief, Cutnose, had lived in former times, and his body lay upon the hillside overlooking the stream. One day J. W. Hunsinger, chief clerk to Superintendent Gibson, was strolling along the brow of the hill and happened to see a rusty

bayonet protruding from the rocks. Mr. Hunsinger, obtaining a shovel, unearthed a skeleton packed round with antiquated munitions of war and the chase. There were rusty guns, bayonets, powder flasks, bullet molds, the iron work from saddles and a great variety of trinkets, but more important than all these in the find was that small copper medal that had belonged to Cutnose. It was another link in the chain of history of that important event over one hundred years ago.

## Quinine Hydroferrocyanide in Hemoptysis

*Also, Other Conditions in Which It Is Useful*

By ALBERT SALIVAS, M. D.

Translated by W. T. Thackeray, M. D., Chicago

[In the August, 1905, number of this journal attention was called to a much neglected but valuable remedy in the treatment of malaria, namely, the hydroferrocyanide of quinine.

The chemical formula of this preparation is  $C_{20}H_{24}N_2O_2$  ( $CN)_6 Fe<sub>3</sub>H<sub>4</sub> + 3H<sub>2</sub>O, whence it may be regarded as a compound of hydrocyanide of quinine and cyanide of iron.$

It is an admitted fact that quinine hydroferrocyanide acts favorably in a markedly smaller dose than the other salts of quinine, in addition to which its limited solubility renders it less objectionable to the taste while in no wise interfering with its medicinal value, the stomachic menstrua of selection being amply able to prepare it for ultimate absorption.

Its remedial value has been proven beyond peradventure, by European physicians, in many cases, notably in tertian and quotidian fevers and in double quartan, the clinical observations having been published by Dr. Van Renterghem and others. In addition to this, it has been demonstrated that hydroferrocyanide of quinine is particularly useful in the recurrent forms of neuralgia; in the first stages of phthisis as a hemostatic, and also as a calmative of the attending cough.

These observations, in addition to the known antiperiodic properties of quinine hydroferrocyanide, should lead to more extended experimentation, not only along the lines already noted, but in new fields where an obscure symptomatology is complicated with fever in any manner periodic or recurrent.

In looking over the literature on the hydroferrocyanide we find that the ferrocyanide of iron has been used in periodic fevers as far back as 1824, and it is more than probable that it was this fact that led up to the manufacture and use of the combination salt.

For the benefit of our readers we append, the first of two articles by Dr. Salivas of France (translated by Dr. Thackeray, from *La Revue Dosimétrique*), on the employment of quinine hydroferrocyanide in phthisis and its attendant ills and trust that this agitation of the subject will lead our friends to make further experiments with the drug and report their findings for the benefit of all concerned.—Ed.]

**H**YDROFERROCYANIDE of quinine is a salt composed of hydrocyanide of quinine and cyanide of iron. It is practically unnoticed in official medicine; nevertheless, on the other hand, it

plays a relatively important role in dosimetric practice.

#### Testimony of Burggraeve, Laura, and Others

Burggraeve says: "The hydroferrocyanide of quinine is an excellent compound, inasmuch as the combination of the iron and the hydrocyanic acid augments the action of the quinine to a very marked degree, so that it is not necessary to administer as large doses as of the other salts of quinine. It is an error to suppose that the hydroferrocyanide of quinine does the work of the quinine only. This salt differs from all the others, medicinally as well as chemically."

Dr. Laura states that the hydroferrocyanide of quinine is a good antiperiodic, while at the same time it is a sedative and antidyscrasic, and is indicated in intermittent fevers—above all, when there is a marked diminution of the red corpuscles and when complicated by anemia.

Hydroferrocyanide of quinine exercises also, as described by Laura, an accented sedative action, principally upon the cardioarterial circulation.

The salt has rendered very great service in the hands of Dr. Van Renterghem, (1) as an antirecurrent in intermittent fevers and in recurrent neuralgias; (2) as a defervescent during the febrile stages of various diseases; (3) as a sedative to the cough of pertussis and in the first stage of pulmonary consumption; (4) as a general tonic and reconstituent of the blood.

Dr. Lannois demonstrated to the International Congress of Alkaloidotherapy, in 1900, the advantages to be gained by the use of quinine hydroferrocyanide in the rebellious hemoptysis of tuberculosis. He described a man under his observation, aged 40 years and in the third stage of pulmonary tuberculosis, with spitting of blood, which had resisted treatment for eight days, but which was rapidly arrested by the administration of three centigrams of the hydroferrocyanide of quinine given every hour. This particular case of Dr. Lannois' is explained, very probably, by the modifying influence, as described by Laura, which the

hydroferrocyanide of quinine exercises upon the cardioarterial circulation.

The many diseased conditions to which the hydroferrocyanide of quinine is applicable suggests to the physician a more careful study of this chemical. There are, first, those mentioned by Dr. Van Renterghem and concerning the sedative action of quinine hydroferrocyanide in the first stage of pulmonary phthisis; then the note by Dr. Lannois and his description of its hemostatic action in the case of persistent hemoptysis.

#### A Concrete Example

About two months ago I had a patient suffering from spitting of blood, more or less abundant, persisting during three weeks, and against which all treatment had failed: ergotin, hamamelis, tannin, rhatany, ferric chloride, injections of morphine, dry-cupping, sinapisms, ice, and absolute repose had been tried without obtaining relief.

I had, at that time, occasion to see our excellent coworker, Dr. Toussaint, to whom I described my perplexity. In reply, he referred me to the paper of Dr. Lannois. This paper I had, but which, I frankly confess, had been forgotten. I then had recourse to the hydroferrocyanide of quinine (3 or 4 centigrams every hour) and I noted with pleasure, in about six hours, the complete disappearance of the bloody sputum which caused me so much worry.

Since then I have used the hydroferrocyanide of quinine in combating hemoptysis in four other patients, and each time I followed the counsel given by Dr. Lannois, with success.

In all of these cases I have succeeded when all other ordinary means have failed. I believe, therefore, that I am rendering a service to my dosimetric coworkers in calling to their attention the suggestion made at our Congress of 1900 and warning them not to forget it as I myself had done.

Noting the success which I obtained from the employment of quinine hydroferrocyanide in hemoptysis, I conceived the idea of utilizing this drug in combating the evening fever of tuberculosis. I have not yet used

it, and I do not know that it will prove any more effective than the other salts of quinine, consequently I shall accompany it with the dosimetric trinity.

**Its Sedative Action in the Cough of Tuberculosis**

It depends upon my experience whether or not my idea will be proven to be of value in this particular, but it has incontestably a calming effect upon the cough. The clinical observations that I have made absolutely justify the claims of Dr. Van Renterghem upon this point. One of the most striking examples that I have seen is that of a young girl of eight years, both lungs badly diseased but especially the right one, difficult and incessant cough, slightly relieved by codeine and which almost disappeared in a day when I added the hydroferrocyanide of quinine to the codeine.

Therefore there can be no question as to its value as an antihemoptysis or to its positive action as a sedative of the cough of

phthisis, and in addition, it has the advantage of being both a tonic and a constituent of the blood. We understand, therefore, the opportunities which it offers in the treatment of pulmonary tuberculosis.

I have seen but few reports by dosimetrists upon the employment of this drug in this disease. This is regrettable, and it would be desirable to have recourse to it more frequently in combating an affection against which we have so little to depend upon.

I have proven the great value of this agent in my own hands and offer it to my coworkers, trusting that they will profit from it. I am fully convinced that it will render good service in a number of conditions, while at the same time they will be relieved from serious embarrassment.

Hydroferrocyanide of quinine is, above all, capable of controlling hemoptysis where other remedies fail, a fact which should never be forgotten.

## Some Obstetric Disasters

*A Record of Some Personal Experiences*

**By B. L. EASTMAN, M. D., Kansas City, Missouri**

Surgeon and Gynecologist to the Missouri Hospital for Women; Former Assistant in the Lauder Hospital for Women, Berlin; Former Professor of Gynecology in the University Medical College, Kansas City

AM moved to write this little story of some obstetric mishaps by the recollection that whenever I meet a few doctor friends in general practice, the conversation always drifts to a talk on obstetrics. And whether these cases from private practice, so informally discussed, involve a scandal, a tragedy or a joke, they are ever interesting and always instructive.

As an interne in a great Chicago hospital, I had a very good obstetric service, but in private practice, as a young doctor, I had less than I felt entitled to. My country patrons gave me their surgery willingly, but passed me by to call the older man in practice for their obstetrics. At the time it

hurt me sadly, but I feel now that perhaps they were wiser than I thought. My later hospital and private work in gynecology, however, have made up for it in a way, for this brings with it consultation work of which a great deal has been in operative obstetrics. So what was missed in normal obstetrics is made up for in the field of obstetric pathology and obstetric surgery. But I am free to confess that what little I do know of practical obstetrics has been gleaned from talking with men in general practice rather than from books.

Hence these cases are put in print in the hope that someone who has had a like experience may be made to feel that he is not

the only one who meets misfortune. Possibly also this paper may stimulate others to similar reports of unusual cases.

#### Eclampsia Following Normal Labor

This case, like the others mentioned, was a consultation-case, and while I had to bear a share of the blame, I got off lightly in comparison with the family doctor who was in direct charge.

The patient was a woman of twenty-five, married several years, and desirous of having a baby. When she finally became pregnant, the old ladies in the neighborhood "encouraged" her by relating numerous incidents from their ripe experience where women who had failed to conceive early in married life had had severe labors, "instruments used," fits, blood poisoning, milk-leg, fever, and various other mishaps. By the seventh month, in fact, the old ladies' council had decided far and near that it was to be a bad case, and so the patient, her family and her husband were in a panic.

The family doctor, a man of mature years and who had known and treated the patient from childhood, raged when he heard this gossip and went out of his way to hunt up the chief croakers and figuratively took their hides off. To counteract this croaking, he went to the other extreme of optimism, and thereby laid himself open to the stunning blow awaiting him.

The end of the pregnancy came, everything apparently was normal, and the good doctor was called out from town. It was a cold winter day, and for a minute or two after reaching the house he stood at the stove and talked to the old women who were in attendance. They assured him that everything was all right so far, the patient had had a few pains, and so forth, and was sleeping. This news didn't cheer him as they thought it would, and one look at the patient's face a moment later told him something was wrong, so turning back the covers he found the baby in the bed between the mother's knees and cyanosed! There wasn't much time for talk, but what he said to those amateur nurses was short and to the point:

Before he could tie the cord and expel the placenta, the patient went into a clonic convulsion. And she had twelve of them in the next four hours.

I saw the woman in consultation with my friend about that time, and while she grew a little better for a short while, the convulsions recurred in spite of chloroform, veratrum, chloral and bromide, and she died twelve hours after the first convolution without regaining consciousness.

Happening early in my practice, this case impressed me powerfully with the great responsibility that the obstetrician shoulders when he goes into any case, no matter how simple and normal it seems to be in the start. Here was a catastrophe that came like a bolt from the clear sky, without warning, and with no possibility of preventing it or preparing for it.

All the skilled obstetricians in the country could not have saved that woman, and the family doctor alone, unused to such desperate cases, and too honest to dissemble, had to bear the brunt of the fight and take the odium of defeat. The old ladies revenged themselves plentifully on him, and the memory of this case stayed with him all his life.

#### Prolapse and Inversion Following Second Stage of Labor

This case was in the hands of a man who had had much obstetric experience, but who was not a very active student of medicine. He called me hastily one night to help him, saying that he had a bad "hemorrhage" to deal with.

Arriving there, I found the woman had been delivered a short time before of a living child and a severe hemorrhage had immediately begun. The woman was barely conscious, cold, pulseless and blanched to the color of white marble. The bed and surroundings were flooded with blood, and altogether the picture was as ghastly as could well be imagined.

Between the woman's thighs lay the inverted and prolapsed uterus, with the placenta still attached to the fundus. The uterus was about eight inches long, tapering

gradually to its vaginal attachment, but without any ring. It was, in fact, completely inside out. The hemorrhage had ceased because all the blood that the heart could pump through the vessels supplying the uterus had already been lost.

I hastily peeled the placenta off the uterus, pushed the latter back into the vagina, and then reinverted it. Following this replacement, hot antiseptic irrigation of the uterine cavity was begun, but quickly discontinued, because the organ had no contractility. The cervix was then seized with a tenaculum, pulled down to the vulva and the cavity packed with cotton twisted into a rope. External heat was applied, and the patient given strychnine and whisky hypodermically, but she died within a few minutes, just as we were beginning intravenous transfusion.

I have many times thought of this case, and wondered whether anything more could have been done, but have never been able to answer the question satisfactorily to myself.

In looking up the statistics afterward, I found that while partial inversion of the uterus had frequently been observed, this particular combination of total prolapse and complete inversion was one of the rarest accidents in obstetrics. Hirst reported that there was no case in the records of 250,000 labors in the Munich Maternity Hospital. In the Dublin Rotunda one case had been observed in 100,000 labors.

With these facts in mind, knowing that such a case is almost surely fatal, and knowing further that only a handful of men in the world have ever seen or ever will see such an accident, what can be said of the doctor whose fate it is to have this ghastly thing happen suddenly and unexpectedly to his patient? He certainly is entitled to the sympathy of his professional brothers; but this is of little comfort to him as compared to the discredit which the laity heap upon him for such an unfortunate outcome of the process normally supposed to be simple and without great danger to the mother.

#### Puerperal Septicemia Cured by Irrigation

This patient was nineteen years old, a primipara, delivered of an illegitimate child

at full term, in January of this year. The labor was normal throughout, the child was of average size, and everything was normal except a small tear in the perineum, which was immediately sutured by the obstetrician. At the time of her delivery the woman had a temperature of 100 degrees, but this was attributed to indigestion and nothing further was thought of it until the fourth day, when the temperature suddenly went to 104° F., and the pulse to 110. On the fifth day the temperature was 105 degrees and the pulse 120.

I saw her at this time, in consultation with her doctor, and found her quiet, conscious, but slightly dazed. The skin was hot and dry, the cheeks were flushed, tongue was coated, and red at the edges. The abdomen was soft and flaccid, and not sensitive, with no indication of peritonitis. Temperature was 105° F., and the pulse had risen to 130 and was small and wavy. The uterus was partly subinvolved, and there was a slight vaginal discharge, practically without odor. She had twice been lightly curetted by the obstetrician, but nothing had been found, and the only result had been to send the pulse and temperature still higher.

The outlook for this patient was decidedly bad, for she was evidently in the midst of a very grave lymphatic septicemia, secondary to a puerperal infection. Under these circumstances we considered three plans of treatment, namely:

The first was the expectant plan of depending on tonics, stimulants and forced feeding; a plan which has the sanction of some of the best authorities in operative obstetrics.

The second plan was a radical operation, which meant the removal of the uterus by the vagina.

The third plan was to consider the uterus an abscess cavity, extensively and virulently infected, needing irrigation and drainage as the chief indication. This plan seemed to have more logic than the first and less danger than the second, and with very little discussion we adopted it forthwith.

Accordingly, two soft-rubber catheters were passed into the uterus through the

cervix, one small, for the inflow, and the other a No. 26 French, fenestrated, for the outflow. These were left long and secured in place by a suture through each one and the corresponding lip of the cervix.

The irrigating apparatus consisted of a fountain-syringe hung just above the level of the patient's body and connected to the smaller catheter, with such regulation that the fluid came out in drops. The bag was filled with a 1:500 formalin solution at a temperature of 110° F., and was kept full of this. Drainage from the outflow tube was made into a bucket at the foot of the bed by means of a Kelly pad, rubber sheets and the raising of the head of the bed.

This irrigation was kept up continuously day and night, for nine days. Along with it were given enemas of whisky, and saline solution by the drop-method, during the first day.

During the first four days her condition remained stationary, and at one time she was thought to be dying. After the fifth day her condition improved gradually, but the high temperature and fast pulse did not go down until the eighth day.

The tubes were removed on the ninth day, when it was found that the solution, or the water, or the pressure of the tubes had caused considerable necrosis in the vagina; but this healed readily and without any bad results. The patient made an otherwise slow recovery, and was confined to bed for about four weeks in all.

This was the fourth case I have seen of acute puerperal lymphatic septicemia, the others dying in from seven to twenty days.

Whether this woman's life was saved exclusively by the uterine irrigation or whether she would have gotten well under the expectant treatment cannot, of course, be positively decided. But I shall always believe that the irrigation and drainage used in this case fulfilled the surgical indications and were the direct means of saving her from a quick and certain death. The more I view this case, the more satisfied I am with the treatment, and the more I am convinced

that we translated the conditions promptly and met the indications exactly.

The infected uterus in this case, and in all such cases, was only a large abscess-cavity, and the important idea was to secure free drainage out of the body and to remove in the easiest and safest way the poisonous bacterial toxins by the only adequate method, that of irrigation. That this plan would work in all cases might be saying too much, but its ease, simplicity and safety so recommend it that I shall certainly use it hereafter for every one of these unfortunate patients that I may encounter.

#### **"Explosive" Pelvic Laceration in a Forceps Delivery, Due to Incomplete Anesthesia**

This was also a patient of the doctor who had charge of the preceding case. The two experiences piled up on him almost in succession and gave him great distaste for obstetrics, although a careful review of both failed to show any negligence of any sort on his part.

The patient was a young primipara, unusually nervous, who bore the pains of the first and second stage with very little fortitude. The labor was a little tedious and so on account of her clamor the doctor applied low forceps after the head came down to the perineum. She was at all times hard to control, nor did the nurse have her completely under chloroform at any stage.

As a result, when the occiput began to distend the vaginal outlet, the patient woke suddenly and in a frenzy combined all her strength in one desperate effort—before the forceps could be removed or the head held back, the head, forceps and shoulders were shot through in one motion. The rest of the child was delivered immediately, and the placenta followed. After it came a rush of blood which the nurse described as being the size of a man's wrist. There was no time for hemostasis or irrigation, so the vagina was speedily packed with cotton and a firm pad and a tight bandage applied to arrest, by pressure, the tremendous bleeding which had started.

I saw the woman with her doctor two hours later, and we put her under ether at once,

without making any preliminary examination. As soon as she was asleep, I removed the packing and after getting rid of the clots and loose blood by irrigation I decided that I had encountered the worst pelvic laceration in my experience to date.

The cervix was split transversely on both sides to and into the broad ligaments, exposing the uterine artery on one side, and the lips hung down, in a loose gaping fold, like the opening of an old-fashioned tobacco-sack.

The vagina presented a very unique appearance, and the anatomy was so distorted that it was difficult to replace the various loose-hanging shreds, fragments and flaps in such a way as to restore the caliber of the pelvic outlet.

First, the posterior vaginal wall was split in the middle line from the cervix down, to and through the perineum. These flaps of vaginal mucosa were torn loose from the rectum behind, from top to bottom, for one inch on either side, showing the paler wall of the rectum through the entire distance. Second, at the vaginal orifice a tear ran on each side upward and outward for an inch, leaving the lower part of the vagina dissected loose from the perineal body. Third, the perineum itself, including the rectovaginal septum, was split in the middle line from top to bottom, and ragged and contused. Fourth, the front of the rectum was laid bare on each side for at least three inches, and the lower inch of its anterior wall was split in a line with the tear through the perineum and the posterior vaginal wall. Fifth, the sphincter ani was torn through a little to one side of the tear in the rectum, leaving a half inch of its longer end sticking up as a little stump. Sixth, the anus was torn loose in its whole anterior semicircumference. In addition to the major lacerations mentioned, there were several short tears in the lateral and anterior vaginal walls.

The pelvic outlet looked for all the world as though it had been the seat of an explosion, and the problem of restoring anything like normal anatomy or function to such a mass of wreckage was a puzzling one.

To test a man's patience and ingenuity still further, the patient's physical and financial circumstances were such that removal to a hospital was impossible. So we had to go ahead with the repair subject to the handicaps of private-house surgery, including a coal-oil lamp for illumination, the kitchen table, with the servant girl for second assistant. This latter individual collapsed and had to be dragged out just after we had gotten nicely under way.

The operation was as tedious as any I have ever undertaken. Without going into details, it consisted in a repair of the cervix; suture of the rectal wall; reunion of the divided ends of the sphincter; reuniting the submucous tissues of the vagina and perineal body with buried sutures; and, finally, an almost endless course of suturing the vaginal mucosa itself.

After the operation the patient was almost in collapse from the unavoidable oozing during the operation and the tedious operation itself, requiring more than an hour for its completion, all this added to the primary hemorrhage.

In spite of the hemorrhage and unfavorable surroundings, however, the woman made a very good recovery and with a surprisingly good plastic result. The action of the sphincter was restored and the caliber of the vaginal canal made nearly normal; with also a fairly good perineum. Some of the deeper sutures gave way during the first ten days and a small rectovaginal fistula resulted, which, however, closed spontaneously within a month.

This is a fair sample of the type of accidents that can befall any man in general practice, taking obstetrical cases as they come, and he is sure of being forced to work with insufficient help. Under profound anesthesia in the second stage this expulsive blast might not have occurred, and the result in this way might have been prevented; but what man in general practice is usually allowed to have help that he often feels is needed in these cases.

The family, as a rule, are too apt to feel that, if they employ a doctor for the delivery, and enlist some old lady to help with the

housework, they have done their Christian duty, and perhaps a little more. The doctor's feelings, when he gets caught in a case like this, would hardly do to expose in polite society.

#### General Reflections

Consultation work in gynecology and obstetrics gives me an ever increasing respect for the man who faces the problems in obstetrics, and it teaches me more and more, with each passing year, that obstetric work in general practice is not only underpaid, but undervalued as well, both by the laity and the profession itself.

It is true that the average obstetric case will go on to normal labor and through a normal lying-in period, but there are many, very many, which do not do so; and when an obstetric case is bad, it is like the little girl who had a little curl, for it is very, *very* bad.

The internist meets failures, and the surgeon has his share of poor results, but both can safeguard themselves and always be ready for a dignified retreat. But when a labor-case in private practice goes bad, it is simply bad all over, and no explanation ever satisfies the family. Obstetric disasters

come like a bolt from a clear sky, without warning, without hope of prevention, and only too often without chance of salvation.

The men who are doing obstetrics in general practice are facing dangers which they cannot see, and often meeting disasters which human ingenuity cannot conquer; they work generally with untrained help, in unfavorable surroundings, and always with a suspicious and hypercritical audience. These men break their rest at night, their nerves are rawed by the night-long clamor of the patients, and they face the ever present danger of some accident or incident which may hold them back for years, or even ruin reputation itself.

They deserve, both in pay and public respect, a dozen times what they receive, and the indifferent surgeon or the blasé minor specialist who refer to obstetric work as "granny doctoring" are as far from the real truth as their petty intellects can ever wander.

So here's good luck, good fortune, and better appreciation for the men who are assisting humanity in its passage under that great (pubic) archway of human life; may all their cases be easy, their mishaps few, and the fees large and frequent!

## A Case of Cesarean Section

*With the Delivery of a Living Child*

By CLARENCE W. McELHANEY, M. D., Greenville, Pennsylvania

THE following case of cesarean section is of considerable interest from the standpoint of the method of anesthesia as well as the history of the patient.

Mrs. H., now twenty-eight years old, was born in South Wales, removing to this country with her parents at the age of nine. In her infancy she was very healthy and strong, and walked before she was nine months old. Her mother states that, when she was about ten months of age, after she had been playing in the yard with the other children one day, she was brought into the house unable to move her left leg. There

was no history of her falling or injuring her leg in any way. The child did not complain of anything or seem to suffer in the least, neither did she complain when they moved the leg, but she was unable to move it herself. There was no illness at this time and with the exception of the paralysis she was in perfect health. She never after walked again without help, and always used crutches from early childhood.

They took the child to a number of doctors, but not one seemed to know what the trouble was, and no treatment seemed to benefit her. The left side of the pelvis and

leg did not develop well, and the leg is now about three inches shorter and much smaller in circumference than the right one. Feeling in it is perfect, but she has no power to move it. The right side of the pelvis and the right leg developed normally in size. She never had any sickness in her life except typhoid fever at the age of fourteen. Began to menstruate at thirteen, and aside from the deformity has always been a healthy, robust girl.

#### The Condition at the Time of Pregnancy

At the time of her marriage she was, with the exception of the left side of the pelvis and leg, an unusually well-developed young woman. When she became pregnant she consulted several physicians as to the advisability of having an abortion produced, for her family felt that on account of the deformity she could not bear a living child. All of the physicians who examined her agreed that the deformity of the pelvis was so great that it would be impossible for her to be delivered of a living child. The left innominate bone is so little developed that the inlet to the pelvis is reduced in size to less than two inches anteroposteriorly, and the transverse diameter to about three inches. Dr. S. M. Zeigler of Greenville, Pa., with whom I was associated in the case and to whom I am indebted for permission to report the same, advised her to wait until full term and have a cesarean section performed. She accepted his advice and placed herself under his care with that end in view. Calculations fixed the termination of pregnancy at about December 25, 1907, and on December 18 she went to the Greenville Hospital for operation the following day.

The woman was very carefully prepared for laparotomy the evening of the 18th and she rested well during the night. On the morning of the 19th, at 7:30 o'clock, she received a hypodermic injection of morphine, gr. 1-4; hyoscine, gr. 1-100, and cactin, gr. 1-67. This dose was repeated at 8:30 a. m. and the patient taken to the operating room at 9 in a semiconscious condition. A few whiffs of chloroform rendered anesthesia complete and the operation,

which was performed by Drs. S. M. Zeigler, C. W. McElhany and J. H. Martin, proceeded with.

#### The Operative Procedure

The abdomen was opened by a median incision extending from two inches above the umbilicus to the pubes. The uterus was delivered outside of the abdomen and



The patient and her child

the incision clamped together by a small double tenaculum. Hot towels were packed around the cervix and over the abdominal incision to prevent possible contamination from the contents of the uterus. The writer grasped the cervix and broad ligaments with both hands, controlling the circulation, while Dr. Zeigler made a median incision through the anterior wall of the uterus. The membranes were ruptured and the child delivered by grasping the legs and lifting it out into a towel held by a nurse; the cord was clamped and cut, and a squalling child relieved our apprehensions in that direction. The hemorrhage was

moderate from the cut in the uterine wall, but this ceased almost entirely when the placenta was removed and uterine contractions, which were very firm, took place.

We had previously decided, upon the solicitation of the family, to remove the uterus, for the danger of infection seemed less from removal than when attempting to save it. Also, we did not think our patient should again be subjected to the dangers of a possible pregnancy. At this point manual compression was replaced by a piece of rubber tubing bound tightly around the cervix, which controlled all hemorrhage. We then tied off the broad ligaments, separated the bladder from the anterior wall of the uterus and amputated the same at the level of the internal os, doing a typical Porro operation.

The patient required no chloroform during the greater part of the operation. While making the abdominal incision, tying the broad ligaments and dissecting the bladder were about the only times she required any until it came to closing the incision. The entire amount used during the operation was about four drams, and Dr. Martin, who gave the anesthetic, states that he never had a patient take it more easily and smoothly, and require so little for such an extensive operation.

#### The Postoperative Condition

The patient left the operating table with a pulse of one hundred and in very good condition. She regained consciousness at 1 o'clock p. m.; did not suffer any pain and slept at intervals during the afternoon. At

9 p. m., however, she was suffering so much pain that the nurse gave her 1-4 grain morphine hypodermically, and this was repeated once during the night. On the 20th she was quite comfortable, with a pulse of 90, and temperature 98.8° F. She vomited at 9 p. m., and at intervals during the night. For several days she had what we considered to be a paralytic ileus, vomiting at intervals a green fluid, abdomen being quite distended, bowels inactive, pulse accelerated and temperature slightly raised. By using calomel in divided doses, magnesium sulphate, and glycerin enemata, besides eserine salicylate and strychnine hypodermically, peristalsis was reestablished and she went on to a good convalescence. A stitch-abscess in the upper part of the incision gave her a good deal of discomfort, but she left the hospital, at the end of five weeks, in good condition.

Today she weighs 145 pounds, does all of her housework and seems to be perfectly well, and has as sturdy and healthy a boy as can be found anywhere. We were particularly pleased with the action of the anesthetic used, hyoscine, morphine and cactin supplemented by chloroform, and believe we should use the same method in another similar case.

What produced the paralysis in the left leg we are unable to say, but believe it must have been some lesion in the lower spinal cord which caused a lack of development of the left side of the pelvis and leg. Have been unable to find any similar case recorded and only offer this explanation of the paralysis for lack of a better one.

**B**E true to your work and to yourself. If you have a conviction, and are conscientious in the belief that you are right, be true to your professions. If you are a rebel, be a rebel out and out, and don't be a goat to leap nimbly back and forth over the fence. Never apologize for either your faith or your profession, unless you have reason to be ashamed of it; and, if you are ashamed of it, renounce it and get one that will need no apology.—Dr. George F. Butler, in "Treasures of Truth."

# The Treatment of Typhoid Fever

*A Method of Handling this Disease with Antipyretics, Blood  
Antiseptics and Intestinal Antiseptics*

By M. E. JOHNSON, M. D., Pittsburg, Kansas

ACH of the three measures named in the superscription seem to me to be of equal importance and I should hardly think of trying to manage a case without all of them. How I could dispense with any one of them without detriment to my patient I do not know, and which one could best be dispensed with is difficult for me to tell, for I have such gratifying results with the combination that I use them all at once, and first, last and all the time; and the fever almost always entirely disappears in fourteen days if not less, nor have I had a second case in any family at any time. This has been my practice and experience for years. All my typhoid patients get well, and very few will have fever up to the twenty-first day.

## How I Do It and What I Do It With

First clean out the bowels thoroughly with good large doses of calomel followed with a saline laxative. See that this is thorough; it may take two or three days. As soon as the alimentary tract is thoroughly cleaned out, commence with some good intestinal antiseptic. I use Abbott's, and I give this every four hours, in from 5- to 10-grain doses, as the case may require, but give it continuously, day and night; nor have I ever found the stomach to be offended thereby.

For a blood antiseptic I use echthol and echinacea in combination, a dose every four hours, in connection with the sulphocarbonates. This treatment is continued without interruption from beginning to end of the attack.

For keeping the fever down I use acetanilid and sodium salicylate combined. I give it in small doses, but of sufficient size and frequency to keep the temperature below  $102^{\circ}$  F., never allowing the fever to remain

long above this point at any time. This measure is also carried out as long as there is any return of fever.

Strychnine, 1-100 of a grain, and Abbott's nuclein are given about once every six hours after the first five or six days. In some cases the strychnine may have to be given in larger doses, but I seldom find it so. If necessary, it is preferable to give this dose oftener than six hours rather than larger doses. In the later stages I like castor oil and oil of turpentine better than the laxative salines for moving the bowels.

Where there is any restlessness or lack of sleep, passiflora incarnata (Lloyd's) is given in doses large enough to produce nervous calm and sleep, which it will do, and the sleep is natural at that. This drug is decidedly preferable to codeine or other opium product. For pain in the stomach, if this should come on, codeine is the thing to give.

Bathe the patient enough to keep him clean, but never with cold water, this not being required when the other remedies are rightly used. Never give sweet milk or lemonade. Never allow iced water, but give all the cool pure water you can make the patient take.

If the foregoing plan is rightly carried out, all cases will be mild ones; many will be cut short. In most cases the fever will not return after the fourteenth day, and in the very few where it does run longer the patients will not be very sick and will be able to get out of bed and walk to the table by about the twenty-first day. I almost feel like kicking myself for some mistakes I have made before I knew better.

Never fear a relapse, because there is nothing to bring it about. The bacilli remaining are so few and so weakened and the resisting power of the patient is so well preserved that they can not do much harm.

Now, if you should desire to see what will happen, just stop all treatment on the tenth or twelfth day and fill your patient full of sweet milk, then see his bowels bloat up like a drum and all manner of bad things happen.

It will take about a week or so to get back to where you left off. This I know, for I just tried it on one of my patients, to see what would happen. So I know for sure what will result.

## Amputation in Lesions of the Hand

*When and How to Amputate*

By RALPH ST. J. PERRY, M. D., Farmington, Minnesota

*EDITORIAL NOTE:—In this month's paper Dr. Perry gives some very valuable advice on when to amputate and when not to do so. He very properly condemns the *furore operativus* in cases where conservative would be far better surgery. His advice is sound, and his directions in cases where amputation becomes necessary are based on personal experience and study.*

THE temptation to amputate is one of the greatest dangers menacing the general public, particularly that portion depending upon manual labor for its sustenance. To the surgeon amputation offers the easiest and quickest way of getting certain cases off their hands; especially those where the patients are unwilling or unable to pay for a prolonged course of reparative treatment and who do not as a rule appreciate the surgeon's efforts to save the mutilated parts and secure the most serviceable result possible.

Strange as it may seem, most persons will pay more for having a hand cut off than they will for having it saved. The public admires the man who amputates; the educated classes think him skilled in his art; the young women adore him for his "courage;" the small boy regards him with awe; and even the victim of the amputation delights in displaying his crippled hand with glowing details of his accident, operation and recovery. Every stump is a walking advertisement of the surgeon's business as long as the possessor lives in the village. The unthinking, improvident workman looks not to the future, but sees only the present with its loss of time and wages, its accumulating expenses, and an unforeseen doctor's bill to pay; he wants to get back to work as

soon as possible and considers neither the present sacrifice nor its remote effects.

### Don't Amputate Rashly

And yet, in spite of the saving of labor and the ethical publicity, my advice regarding amputations in injuries to the hand is, *Don't*.

The many hours spent in cleansing and dressing purulent hands, in touching them up here and straightening a little there, in encouraging poor granulations at one spot and curbing the exuberant at another, will all bring their reward in the self-satisfaction over a case well handled and the beneficial results secured; possibly in years to come your patient will appreciate your efforts. Remember, too, that in surgical practice honors and glory are most evanescent, that those who laud today may damn tomorrow; so be not led astray, but let your best efforts be to save rather than to sacrifice.

### Give Nature a Chance

In most cases of injuries where amputation seems indicated it is best to restore carefully the relations of the injured parts, apply a vulnerary and antiseptic dressing, with a snug but not tight bandaging to a fixed support, and give nature a chance. My experience has been that in the vast majority of cases

the parts will heal to such an extent as to render amputation unnecessary or to reduce the amount of tissue requiring amputation to a minimum surprising to the uninitiated.

Nevertheless there are cases where amputation is required, in some immediately, in others after the probationary period demonstrated its necessity. In all amputations about the hand, whether immediate or delayed, for injury or disease, *the following rules should be observed:*

1. Secure as useful a result as possible.
2. Save all tissue possible.
3. Secure as cosmetic a result as possible.

**Strive to Secure Best-Possible Useful Results**

It quite frequently happens that it is absolutely necessary to sacrifice healthy tissues to secure a useful result, as where the surgeon is confronted with the proposition of cutting away healthy bone in order to secure a soft-tissue covering for a stump. Occasionally a short, stubby stump of a finger is an interference with the best use of the rest of the hand and should be avoided by making a metacarpal amputation. Again, the bones may have been destroyed, leaving masses of the soft parts attached to the remaining fragments. The retention and replacement of all this soft tissue is apt to result in a long, flabby, fleshy stump lacking that firmness essential to a finger-end, and which, therefore, is a detriment to usefulness. Cosmetic effects are secondary to usefulness and only call for serious consideration in cases where the injured does not perform any form of manual labor. However, no surgeon is justified in neglecting any factor which would add to the pleasing effect of the result or which, if unattended to, would add to its unsightliness.

In deciding upon an amputation, consider the patient's vocation and station in society,

the future usefulness of the injured hand and the possibilities of prosthetic measures in overcoming the disability. Many a troublesome and useless finger-stump has been transformed into a valuable member of



DR. RALPH ST. J. PERRY

the digital group by means of a simple prosthetic appliance.

**Save as Much Tissue as You Can**

The rule to save all tissues possible requires that we discard all "book amputations," all prearranged methods for mutilating the hand, and adapt our operations to the tissues at command. Emergency amputations of the hand follow no set rules and ignore all typical operations, and the surgeon who would succeed in this work must judge each individual case upon its merits and produce the best results possible with the materials at hand, always bearing

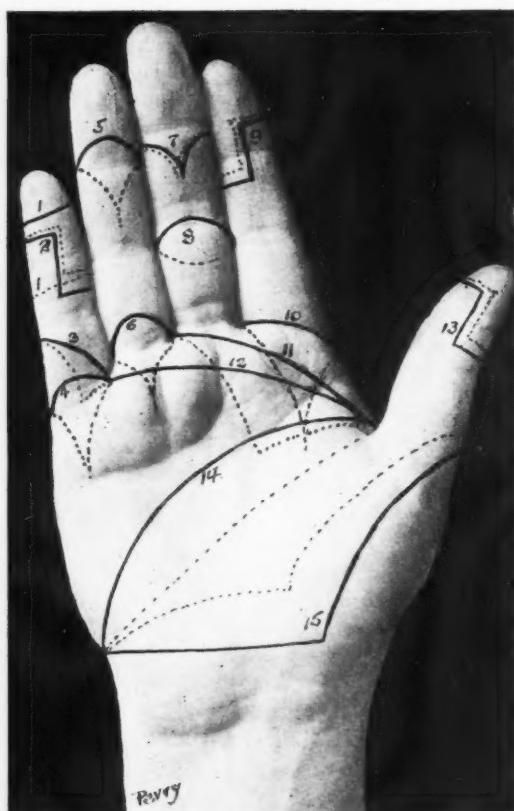


Fig. 1. Showing the lines of the palmar incisions in the several amputations concerning the hand, so arranged that the cicatrix will come on the dorsal surface. Dotted lines show dorsal lines of incision.

in mind that one essential of usefulness. Experience in this work has led to the formulation of a few rules or principles which if carried out are most helpful in effecting satisfactory results.

Never amputate, under any circumstances, if the circulation be good in the injured parts; no matter how badly the bone may be comminuted or how severely the soft parts are torn and lacerated, do not amputate if the blood supply be sufficient to maintain vitality. When tissues die, cut them away, but only dead portions; new granulations will fill in their place.

In covering the ends of stumps the flap should invariably be of tissues from the

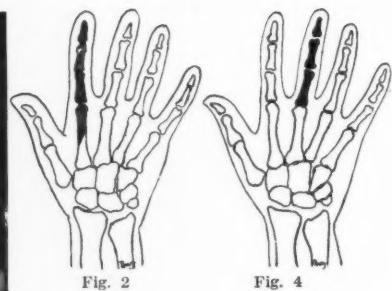


Fig. 2

Fig. 4

*palmar* side. (Fig. 1.) This brings the cicatrix on the dorsal aspect where it is free from the irritation and trauma incidental to the use of the hand. So imperative is this rule that it is justifiable to sacrifice any reasonable amount of tissue necessary to secure the tissues required for a large-enough palmar flap. A palmar cicatrix invariably leads to trouble sooner or later if in the hand of a manual laborer.

A stump which is insufficiently covered becomes painful, tender and ulcerated when put to use, with possibly an adherent scar and limited movement of the parts. Every stump should have, if possible, as much covering as has the normal finger-tip.

Where the cosmetic effect only is to be considered, a dorsal flap may be tolerated if a more slightly stump can be secured thereby.

In making the flaps, the parts should not

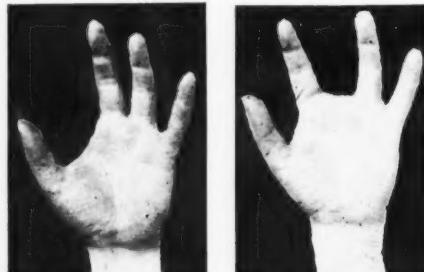


Fig. 3

Fig. 5



Fig. 6



Fig. 8

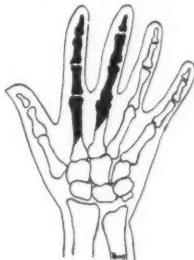


Fig. 10

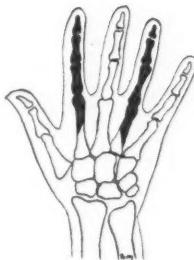


Fig. 12

be transfixated but the flap should be cut from without inward.

#### Finger Amputations

In all finger amputations the ends of the tendons should be sutured together over the end of the bone. If only one tendon be present, the other being torn away, its end should be sutured to the periosteum. This suturing affords an attachment for the tendons, preserves the function of their muscles, helps in forming a cushion tip, and prevents them from pulling upon the stump and thus causing pain, tenderness, ulceration and disability.

In finger amputations at a joint trim away the cartilaginous joint surface and cut off the prominences or knobs on the palmar side of the phalangeal heads.

In cases where only the terminal phalanx is involved and a small part of the nail remains, it is best to remove this remaining portion and dissect away all of the mutilated matrix lest, after healing, a ragged, irregular or deformed nail growth disfigure the finger and possibly increase the disability.

Where the *second or third phalanges* only are injured, the rule is to save all possible. Some surgeons advise against leaving less than half a phalanx, claiming that such a short portion becomes permanently flexed.

My experience does not agree with this; I invariably leave all possible of these phalanges and rarely have seen a permanently flexed stump. The tendons are cared for as described above; the action of one balances that of the other and they are equalized. Even a permanently flexed stump of a second or third phalanx is not a great hindrance and possesses some utility; I have never known a working man who would consent to the amputation of such a finger.

In cases involving the *first phalanx* save as much as possible of the middle finger; but of the index-, ring- and little fingers it is useless to save less than half of this phalanx, as such a short stump comes back of the interdigital cleft and has no grasping utility.

Where the entire first phalanx must be sacrificed in the index-, ring- or little-fingers,



Fig. 7



Fig. 9



Fig. 11



Fig. 13

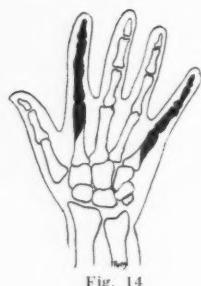


Fig. 14

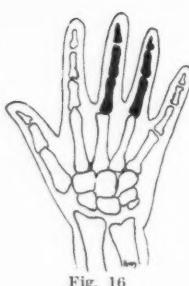


Fig. 16

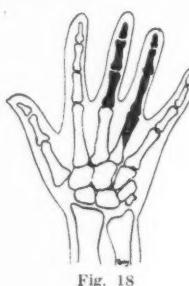


Fig. 18

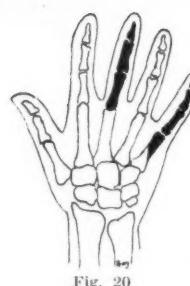


Fig. 20

it is best to remove with oblique section a distal portion of the corresponding metacarpal bone.

Where the middle finger alone is hurt, the metacarpal bone is not to be disturbed, as it forms the median support and mainstay of the hands; its removal causes the index-finger to fall away from the thumb, weakens the hand and compromises its usefulness.

#### **Disposition of the Metacarpal Bones**

The disposition of the metacarpal bones in these cases is a matter of dispute among surgeons, but my own experience and observation has resulted in at present following the practice as outlined below, in cases where the first phalanx must be removed, and which has produced the most satisfactory results as to utility, strength and cosmetic appearance.

1. Index-finger: Remove by oblique section the distal half of the corresponding metacarpal bone. (Figs. 2 and 3.)

2. Middle finger: Do not remove any portion of its metacarpal bone. (Figs. 4 and 5.)

3. Ring-finger: Remove the distal two-thirds of its metacarpal bone. (Figs. 6 and 7.)

4. Little finger: Remove the distal half of its metacarpal bone. (Figs. 8 and 9.)

5. Index- and middle fingers: Remove the distal two-thirds of the index- and the distal one-third of middle-finger metacarpal bones. (Figs. 10 and 11.)

6. Index- and ring-fingers: Remove the distal half of the index- and the distal two-thirds of the ring-finger metacarpal bones. (Figs. 12 and 13.)

7. Index- and little fingers: Remove the distal half of each corresponding metacarpal bone. (Figs. 14 and 15.)

8. Middle and ring-fingers: In workmen handling tools, where the width of the grip is valuable, do not remove any portion of either of the metacarpals except the knobs on the palmar sides of the heads and the cartilage from the exposed articular faces. (Figs. 16 and 17.) In other cases, where a more cosmetic result may be desirable, remove the distal two-thirds of the ring-finger metacarpal, but do not disturb the



Fig. 15



Fig. 17



Fig. 19



Fig. 21

middle-finger metacarpal bone. (Figs. 18 and 19.)

9. Middle and little fingers: Remove the distal half of the little-finger metacarpal bone, but none of the middle-finger metacarpal bone. (Figs. 20 and 21.)

10. Ring- and little fingers: Remove the distal two-thirds of the little-finger metacarpal bone and the distal one-third of the ring-finger metacarpal bone. (Figs. 22 and 23.) [These and subsequent cuts to appear next month, with the balance of the article.—ED.]

11. Index-, middle and ring-fingers: Remove the distal two-thirds of the index metacarpal, the distal and half of the middle-finger metacarpal, and the distal one-third of the ring-finger metacarpal bones. (Figs. 24 and 25, and 24 a, 25 a.)

12. Index-, middle and little fingers: Remove the distal two-thirds of the index metacarpal, distal half of the middle-finger metacarpal, and the distal two-thirds of the little-finger metacarpal bones. (Figs. 26 and 27, and 26 a, 27 a.)

13. Index-, ring- and little fingers: Remove the distal two-thirds of the index- and little-finger metacarpal, and the distal one-third of the ring-finger metacarpal bones. (Figs. 28 and 29, and 28 a, 29 a.)

14. Middle, ring- and little fingers: Remove the distal two-thirds of the little-finger metacarpal, the distal half of the ring-finger metacarpal, and the distal one-third of the middle-finger metacarpal bones. (Figs. 30 and 31, and 30 a, 31 a.)

15. Index-, middle-, ring- and little fingers: Do not remove any portion of any of the metacarpal bones except the knobs on the palmar sides of their heads and the exposed articular cartilages. (Fig. 32.) In cases where the first phalanges of *all four* of these fingers are every one so badly injured as to demand amputation, and it is possible to save even less than half of *each* phalanx, this should be done, thereby preserving to a degree the power of flexion to the palm by flexing the stumps in unison, a movement which is of great value in han-

dling and manipulating tools, machinery, and so on.

The incisions necessary for the removal of a metacarpal bone should always be made upon the dorsal aspect of the hand, and the bone should always be removed by an oblique section, with the cut surface away from the median line. (Fig. 33.) Whenever possible, dissect the periosteum loose before cutting the bone and use it as a covering for the cut surface; results are better if this be done, as cicatricial adhesions to the bone are avoided and there is less apt to be pain, tenderness or ulceration.

A finger ankylosed in full extension in all its joints (Fig. 34) is worse than no finger, and wherever such an ankylosis is an inevitable result of its healing, it is better to resort to amputation, unless the patient will consent to a subsequent arthroplastic operation for the formation of a new joint.

In injuries to the thumb save as much as possible, regardless of the shortness of the stump, possible phalangeal ankylosis or disfigurement. The thumb is the most valuable of the digits, and if the functions of the other fingers be intact, the smallest thenar stump, even if ankylosed, is of immense value in maintaining the usefulness of the hand as a whole.

In amputations through the metacarpus, the thumb being saved, do not remove any more tissue than is necessary to secure a satisfactory palmar flap. When a metacarpal amputation takes in a portion of the thumb, save as much of the thumb as possible.

In amputations through the carpus try to cover the end of the stump with a flap from either the thenar or hypotenar eminence; failing in this, use whatever tissue is available, and if necessary to remove part of the bones to secure flaps, always get the flaps from the palmar tissues.

In amputations at the wrist always preserve the condyles of the radius and ulna, as these prominences afford points of support and fixation for prosthetic appliances.

(To be Continued.)

# System for the General Practitioner

Practical Advice for the Business Side of Medicine

By J. WILLIAM WATSON, A. M., M. D., South Braintree, Mass.

**EDITORIAL NOTE.**—Success in medicine depends upon something more than knowledge and technical training. The knowledge must be systematized, so as to be usable; the technical skill must be added to by observation and study. These things involve order in the physician's office, in the collection and preservation of his literature, in the preparation and filing of his case reports, and finally—and by no means of least importance—the keeping of his accounts. Many a man has failed primarily from lack of system. Every doctor needs to make it a study—and it is help along these lines that Dr. Watson offers in the article which follows.

## II

THE "General and Obstetrical History" sheets will meet many requirements except where you wish to go into a specialty, like the eye, for instance.

coming to my notice that has such numbers. I put a "C" in lead pencil for a house or "call" case, and an "O" for treatment at the office, around the number or date on which it is to be made, and also the special hour, if

### THE HISTORY SHEET POINTS REGARDING ITS USE.

The form is a 'GENERAL HISTORY SHEET' with the following key features and annotations:

- Top Row:** Days of the month (1-31) and a grid for recording charges (e.g., \$1.00).
- Header:** GENERAL HISTORY SHEET.
- Left Column:** Charge to, Name of PATIENT (A. M. W.), Address, Phone.
- Middle Section:** NOTICE other charges for SELF, WIFE, SON, DAUGHTER, STRANGERS.
- Right Section:** BAL. FOR'D ON, CHARGED, TOTAL CHGD., PAID, BAL. DUE.
- Bottom Section:** A large table for recording treatments and remarks, with columns for DATE, MONTH, DAY, TREATMENT AND REMARKS, and rows for various patients (A. M. W., etc.).
- Annotations:**
  - "Always put the name of the head of the family or the one who pays the bill in this space."
  - "Single, Married or Widower."
  - "Under this System you may have several charges against the head of the family on several different ledger sheets. Therefore, when you are settling up these charges, it is advisable when starting a new case that you put a ring around the other members of the family whose accounts are still unpaid."
  - "Draw your pencil through this which you wish scratched out."
  - "To be used in place of Call Book. Put a ring around the date of the next call and each day look through the numbers of that date and call on those marked."
  - "If the head of the family owns a business in town, bring it forward in the ledger sheet and add to the New System any amounts from the old ledger unless you are actively treating some member of that family."
  - "Charge every visit or call at the time it is made, and do not wait for the end of the month and credit it back, as one often does. This is absolutely necessary to keep your accounts accurate."
- Bottom Left:** THE ILLUSTRATED HISTORY
- Bottom Right:** POCKET CASE AND CABINET

Fig. 7. The history sheet

One side of these sheets is illustrated in Figures 7 and 8.

The numbers at the top of the sheet are very useful. This system is the only one

desired, is written above, as shown in the cut. When the case has been attended to the pencil marks are rubbed out and the next engagement is made. Permanent rec-

## SYSTEM FOR THE GENERAL PRACTITIONER

1203

OBSTETRICAL HISTORY SHEET										Bal. For'd on		
										190		
Charge to										CHARGED		
Name of PATIENT										TOTAL CHGD.		
Address										PAID		
NOTICE other charges for										BAL DUE		
DATE	DRG#	TYPE	DEP.	PUSC	BRN	LDR	ANTE	NATAL	TREATMENT	WHERE	DR.	CR.
190												
	A. M.									OFFICE		
	P. M.									MAIL		
	A. M.									OFFICE		
	P. M.									MAIL		
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**Fig. 8.** The obstetrical history sheet

ords are made always in ink, and for this purpose I carry with me three different colors, for "contrasty" effects.

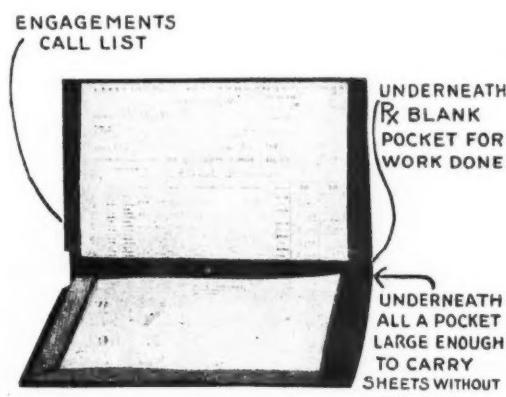


Fig. 9. Part of Curve

tory" sheet with two blanks added for a patient under continuous treatment for nearly a year.

These sheets are best carried in a leather pocket-case, as shown in Figure 9. The engagements are taken from your "Current Cases" daily calendar, spread out and put together in the order that you wish to make your calls. Never take out the "Office Engagements." The "Outside Calls" are placed in the upper pocket, as shown in the cut.

When you return to your office place the work done in compartment No. 1 of "Current Cases." At the end of the day it is interesting to get your total of work done, although this is not necessary; still, every business man wants to know how he stands. I have found it interesting to keep a diary on "The Line a Day" plan, for future reference. Figure 10 shows an actual record (exact

June 26

June 1916  
Pattison Park Co. Cr.  
a 25 lbs. 1.50  
H-23 Three Poles 1.50  
PM-12-20 Three Poles 1.50  
8.00 5.50 5.00  
charge this morning on a bicycle  
Pedometer 894 miles. Cycle 1/6 346 miles

Fig. 10. From the line-a-day book.

size) from my diary taken from the sheets at the end of the day. I have easily recorded some twenty transactions in this way. It is interesting to note where and how you have put in your time.

The \$0.00, \$5.50, \$5.00 is shown in Figure 11, and is self-explanatory. It is entered on this daily and monthly summary sheet, which also gives the grand total from the beginning of the year. These I made with a duplicator and have bound them in book form so the work can be compared for seven years.

When the day's work is completed and these few entries have been made, more for the pleasure of knowing what you are doing than that it is required by the system, the "History Sheets" are filed away, those with engagements in the "Current-Case Calendar," those that are "done" in the "Cases Treated this Month." The latter are filed away in strong envelopes (printed as shown in Fig. 12) by families under the name of the one who is responsible for the payment of the bill. These envelopes are made to order; size 5 7-8 by 4 inches.

## **Filing Envelopes**

If they are cash-paying patients nothing appears on the envelope except the name, address and the diseases. Where there are

Month of JUNE 1910				
Date	Daily Cash Business	Daily Charge Business	Daily Cash Bills Paid	Remarks
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26	10.00	15.50	4.00	
27				
28				
29				
30				
31				
Total				
Grand Total				
Grand Total				

Fig. 11. Daily and monthly summary reports

Fig. 12. Account memorandum

charges, these are noted in the proper place, and the memorandum gives you information as to the time you sent out bills and how your collection proceeds. It is very easy to make out bills from this system as each patient has his own sheet and the account does not have to be culled from a ledger containing all the family record of sickness. For instance, a bill to John Jones would read:

June 1-15.	To professional work (5 attentions).	Self	\$10.00
" 4-10.	" "	(6)	Wife 8.00
" 16-30.	" "	(20)	Son 40.00
			<b>\$58.00</b>

If the patient wants a more itemized account than that, it is very easy to accommodate him. On the outside of the envelope, in the debit column, write the total: June 1-30, \$58.00. Should he pay anything on account, write the time and amount in the credit column: June 20, \$25.00 at 2 p. m. I oftentimes note payments on the "History Sheet" of the head of the family. In this way you have a check on your work. When you are making out your bills it is always a good plan to keep a list of the patients and the amounts they owe. With this always with you you are ready for anyone who wants to pay his bill. A still better way is to get a little pocket-ledger such as Huff Company puts out for a dollar. This contains 300 accounts and is easily revised from month to month.

In the case or cabinet above mentioned nothing but "History" sheets is supposed to be filed away. The convenient daily reminder is not to be used for anything else. All this is for your patients alone.

Every physician should have near his left elbow an "Office Tickler" which can be made to give the days of the week as well as the "Cases Under Treatment," or "Current". This is a great convenience, for here you can place everything that must be attended to—letters to be answered, etc. It will enable you to be a physician that keeps his word and never forgets any engagement. Make notes of your dates and put them in the "Work Done" compartment of your pocket-case, and on reaching the office you can put these dates and engagements in their proper places. It saves brain worry, and the memory can be employed for things more useful.

The "Accounts" drawer shows "a follow-up plan" for collections. By this plan you can see whether your lawyers and collectors are attending to business. Your accounts

are where you can easily find them. You always have a ready finger on the financial end of your business.

In regard to collections, get all the information that you can. A knowledge of law is a good thing. It is in his collections that the physician becomes a business man, a salesman; you are selling your patient a settlement of his account. It is important to know how to write letters that will reach this class of people. There is a little book on "How to Write Letters That Win" which would be helpful to every physician. "Successful Collecting", of less than fifty pages, gives systematic information. There is a magazine on "System" which it would pay any physician to read occasionally, at least until he gets a system of his own well established. Study to save work and make your time count.

## Medical Testimony

*Observations, Experiences and Suggestions*

By A. D. HARD, M. D., Marshall, Minnesota

THE answers of medical expert witnesses often bring disgrace and decrease of professional dignity to the body of men who should occupy a very high position in the minds of their fellow mortals. No calling in life demands more serious and ethical conduct than that of the physician. No human being is called to bear the responsibility of life and death, or to safeguard honor, to the extent demanded of the physician.

No man of any calling should be as strictly honest as a physician. The lawyer may be dishonest, and as a result be even more successful in winning cases thereby. The clergyman may preach ideals that he does not follow nor try to exemplify, and but little if any bad effects follow except to himself. But if a physician fails in his strict duty to his fellow man, sorrow, suffering and death trail in his path. Therefore, any thing which lowers his dignified standing in the

minds of the people injures not only the physician but all those whom he may serve.

### The Doctor at a Disadvantage on the Witness Stand

As a rule physicians are not trained in the school of wordy antagonism which lawyers are so fond of attending, and when, from the witness stand with its disadvantages, he pits his cleverness against that of the questioning attorney, he usually comes out second best in every respect. This is one of the very few instances in a physician's life-work where an unsympathetic audience grasps the chance to laugh at his expense, and the newspapers follow with ridicule and derision. This is deplorable, and should be avoided in the interests of humanity, even if not of the physician himself.

My first experience on the expert stand was in the famous damage suit of Professor Maclean of Ann Arbor against *The Detroit*

*Evening News* for defamation of character. Before going on the stand I was "coached" to disarm the crossquestioning of Col. Atkinson, one of the shrewdest attorneys in the land, by wordy thrusts to the quick of the very heart. I was told to frame an answer in a way to slur the little child of his that at the time lay at the point of death from diphtheria. Words were put into my mouth to hurl at him that would recall to his mind things that he would fain forget, in order to disconcert him in his efforts to twist my testimony into something that would be useful to his side.

I was told by Prof. Maclean that no sum of money would be promised me for my services lest that fact should be brought out to show that my mind was prejudiced and my words would lose their force. And, incidentally, this was taken advantage of afterward to deprive me of my fee.

I knew nothing of the facts concerning the case. As usual, the experts plainly indicated by their testimony on which side they were called, and as the professor made the best showing to the jury, they gave him twenty thousand dollars damages, contrary to justice and equity, I believe.

#### How One Witness Was Tripped

I give this illustration to show the inside of what so often is done by attorneys to win their cases, and its effect upon the medical witnesses who may be dragged into the dirty mess, leaving them in a regretful frame of mind over the matter forever after.

I recall a case where a prominent Indiana physician was tricked into a disgraceful exhibition of himself, to the lowering of general professional esteem, by the clever work of a smart attorney. The physician was asked if the patient was in a condition of "euthanasia" at the time referred to. The physician recognized the word as a medical term, but was not clear in his mind as to its exact meaning. Of course our medical friend did not wish to appear thus ignorant before the vast audience, and he thought that the answer "Yes" would end the matter, so he assumed a dignified appearance of extreme wisdom and said, "Yes, certainly."

The opposing attorney had been burning midnight oil searching for this word, and when he asked the obliging witness to explain to the jury the meaning of that word, "euthanasia," the poor fellow fell down completely, and he was made to appear ridiculous to the audience, worthless in the minds of the jury, and silly in the newspapers, which gave the incident prominence to the disgrace of every physician in the state. But the physicians of Indiana can never again be caught on that word "euthanasia," they will not forget it.

#### Another Catch Question

In a recent trial in Minnesota an ex-probate judge who feels himself to be a shining legal light in the magnificent city of Minneapolis attempted to disconcert a medical expert witness in order to destroy the effect of his testimony by asking him, "How far is it from the anus to the rectum?" The judge did not seem to know anything about those terms and permitted the question to be asked. As will be seen, the question was simply a catch question calculated to lead the witness into the depths of trouble. Luckily for the physician, an idea came to his rescue which solved the problem for him, and left him with flags flying. His answer was, "About as far as it is from the hole of a doughnut to the doughnut, and the answer is about as sensible as the question." The attorney wilted, but later on got even with the doctor by calling him a "skunk" to the jury.

In another suit in Minnesota of recent date the medical experts on the side of a railroad company showed very distinctly by their testimony that they had passes on the road and did not wish to lose them. The jury were impressed with that idea and disagreed instead of rendering a verdict.

The significance of these incidents tally with the results of the Thaw trial, and go to show that a more dignified manner of using medical knowledge for the information of juries should be devised. The method best calculated to conserve professional dignity and due respect for medicine as a science, should exclude all crossexamining by at-

orneys which has for its object the discredit of the witness.

No expert, it is plain, should be called to testify by anyone except the judge who is trying the case. Questions of expert opinion and crossquestions based upon them should be submitted in writing to the judge by the attorneys, and such questions as are considered proper by the judge should be given to the witness to answer as a matter of information to the men on the jury in order that they may arrive at a more nearly correct decision.

The qualifications of witnesses as experts should be admitted by attorneys for each side, and the value of the testimony should be weighed by the jury alone. The re-

mumeration for the expert knowledge called for should be ordered by the judge independently of the outcome of the suit. The expert should be accepted or rejected upon his answers to qualifying questions similar to those asked to a juror.

One thing is undeniable: it is no more right to ridicule and attempt to disgrace a medical expert on the stand than it is to do that to the jury which tries the case. He is entitled to the same careful respect by the attorneys as the judge on the bench, and until this is given, medical expert testimony will continue to be not only worthless as a means of securing justice, but a destroyer of the dignity of the medical profession in general.

### THE MAN WHO FRETS

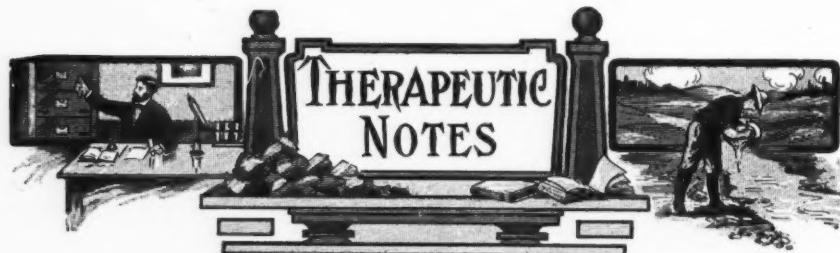
BY L. W. ZOCHERT, M. D.

The fretter he fritters his time away  
On foolishsome fumings and fuss;  
He may know that the flowers are blooming in May,  
But he simply just don't care a cuss!

He'll blankly blink at the blithesome blue,  
But will frowningly look for the cloud;  
If his heart should be singing a tune or two,  
He would fear lest the tune be too loud.

He falteringly fails to go moving ahead,  
Lest in using his feet he should fall;  
Forgetting the while that he'd better be dead  
Than not to be moving at all.

Oh the fretter he fritters his tune away,  
In stewing with strenuous stress;  
For him is no joy and no laughter gay,  
And life is just one danged mess!



## THE TREATMENT OF HEMORRHAGE IN TYPHOID FEVER

Michaelis (*Med. Klinik*, 1908, No. 2) has employed high enemata of a 10-percent gelatin solution successfully to arrest severe hemorrhages in typhoid fever, and warmly recommends the method. That's good—worth trying. But don't forget the importance of intestinal *rest* during these hemorrhages. Atropine is indicated—sometimes morphine also.

## PRECAUTIONS IN THE USE OF FIBROLYSIN

Dr. Stocker (noticed in *Therap. Monatsh.*, April, 1910) says that, since fibrolysin acts as a solvent upon cicatrices of any age, it is important, before injecting the remedy, to ascertain whether the patient has a history of having passed through a severe infection. He has observed a case where vaccination-marks upon the arm, which dated from a vaccination thirty years ago, were considerably inflamed, with production of high temperature, during a fibrolysin treatment for adhesions in the abdomen.

Stocker calls attention to the importance of being careful in the use of fibrolysin in cases of healed pulmonary tuberculosis and in healed ulcerative processes in the gastrointestinal canal, because the scars produced by such healing may be affected by fibrolysin and the disease may be reactivated. He cautions against the use of fibrolysin in the conditions named, because, while any other scar which was to be softened by the remedy would undoubtedly be affected, these healed lesions would in like manner

be influenced and a new ulcer in the stomach or intestines, or a new phthisical process in the lungs might be produced, which undoubtedly would lead to severe disease.

## FAVORABLE RESULTS FROM ATROPINE IN DIABETES

Rudisch (*Therapeut. Monatsh.*, March, 1910) has seen surprisingly favorable results in diabetes from treatment with atropine. He employed the sulphate and the methylhydrobromide of atropine. As a rule the dosage of one-third of the maximal doses was sufficient, but as much as 0.003 Gram of atropine sulphate and 0.032 Gram of the methylhydrobromide three times a day was employed without untoward results.

## THE TREATMENT OF HEMORRHOIDS

Boas (*Therap. Monatsh.*, March, 1910) recommends a peculiar mode of treating hemorrhoids. It consists in letting the patient force the hemorrhoids out as much as possible and then not reducing them. After a short time congestive edema occurs, followed by atrophy and then by healing. Boas has carried out this very simple method in eight cases, with good results. It causes but slight trouble and is entirely without danger. It is, of course, only adapted for internal hemorrhoids.

## CHEWING GUM IN TYPHOID FEVER

Among the excellent therapeutic suggestions given by Dr. Young of the Marine Hospital, Chicago, at a recent medical meeting in this city, was one as to the use-

fulness of chewing gum for the dry tongue and mouth so characteristic of typhoid-fever. When the patient is generously supplied with the "gum" and chews it faithfully (as he is pretty sure to do) the mouth becomes moist and the teeth, which have been covered with sordes become and remain white throughout the illness. This simple remedy has been such a comfort that as a matter of routine he now supplies chewing gum to all his typhoid-fever patients.

#### THE MILLER DIET IN TYPHOID FEVER

The tendency at the present time is to provide patients suffering from this disease with a more generous diet. The "Miller diet," so called, as employed in one of our Chicago hospitals, is as follows: At 8 a. m. the patient is given a soft-boiled egg and some well-cooked cereal, with cream; at 10 he is given egg-nog; at 12 m., 50 Grams of bacon, a soft-boiled egg and a custard; at 2 p. m. another egg-nog is given; at 4, gelatin with cream and some palatable fruit sauce; at 6, egg, bread and butter, with cream. Under this diet it is stated that the mortality has decidedly diminished.

#### CHROMIUM SULPHATE: IS IT OF VALUE IN INFANTILE PARALYSIS?

On account of its action in correcting or preventing the degenerations of fibrous connective tissue, and in view of the fact that changes of this kind undoubtedly take place during the course of acute anterior poliomyelitis, it has been suggested that chromium sulphate might be a valuable remedy in this disease. So far as we know it has never been used in these cases, but it is certainly worthy a trial, especially during the stage of early convalescence. Who will try it out and report?

#### THE TREATMENT OF CHLOROSIS

Assuming that in chlorosis the hemoglobin-content of the blood is not diminished, but the plasma increased, Melland (*Brit. Med. Jour.*, Dec. 11, 1909) claims

that the disease may be cured, without the administration of iron, merely by reducing the blood-water. He has employed this principle in the treatment of chlorosis in actual practice, depriving the organism of water by diuresis, by limiting the amount of water ingested, as well as of all fluids in the food, finally by prohibiting salty food. With such treatment the body-weight is rapidly reduced, although the patient feels much better. Theoretically a complete cure may be obtained. Melland's experience shows, nevertheless, that a cure is promoted by the addition of iron to the above treatment.

#### ANEMIA

Castro presented the following scheme for treatment:

	DOMINANT
For anemia proper	{ quassain strychnine arsenate pepsin and diastase
For cachectic anemia	{ laxative saline strychnine hypophosphite
For essential anemia, chlorosis	{ iron { arsenate phosphate lactate valerianate salicylate  tannic acid strychnine arsenate strychnine hypophosphite

	VARIANT
Palpitation . . .	digitalin
Gastralgia	{ codeine hyoscyamine morphine hydrobromide atropine sulphate cocaine
Cephalalgia	{ congestive . aconitine " . . . . ." anemic { Gregory's salt ammonium benzoate monobromated camphor
Neuralgias	{ periodic { quinine valerianate quinine hydrobromide irregular { gelsemine guarana
Constipation	{ podophyllin euonymin
Amenorrhea	{ iodoform iron arsenate
Menorrhagia	{ ergotin tannic acid strychnine sulphate

#### ACUTE ANTERIOR POLIOMYELITIS

What can we do in cases of this kind, now so prevalent? The following outline of

treatment has been suggested: First, of course, we should secure rapid elimination. Use small doses of elaterin (1-67 grain or more) half-hourly, or calomel and podophyllin in 1-6 grain doses, followed by laxative salines. Maintain intestinal cleanliness with sulphocarbonates. Keep the patient quietly in bed in a darkened room. Gowers says he should not be allowed to lie on the back on account of the danger of increasing the local congestion, but pillows under the back will raise the spine. Fly-blisters applied at intervals along the spine may be helpful. To combat the toxemia use calcium sulphide and echinacea, pushing in full dosage. Nuclein should be of very great service. Give 20 minimis on the tongue every four hours, or for prompt action administer it hypodermically. Arsenic iodide is another valuable remedy, perhaps most useful during beginning convalescence. Inunctions with unguentum Credé are suggested.

#### GELATIN ENEMAS FOR COLON CATARRH

The treatment of chronic catarrh of the colon with hot injections of gelatin is recommended by L. Von Aldor (*Therap. Monatsh.*, 1910, No. 4), who reports his experiences in seven cases of obstinate, severe cases of this affection associated with diarrhea, having had good results from the use of high enemata of a 10-percent solution. These applications not only diminished the diarrhea, but also had a beneficial effect on the inflammatory condition of the bowels.

One hour before the treatment the patient receives an enema with one-half liter of water of a temperature of from 25° to 28° C., this being discharged as completely as possible, after which the patient remains quiet for one-half to three-quarters of an hour. The injection of the 10-percent sterilized gelatin solution is then given with the patient in the Sims position, from 40 to 80 Cc. being injected through the colon-tube at a temperature of from 45° to 50° C. The patient then lies on his back for two hours, with hot applications on the abdomen. In this manner the injection will be retained in the majority of these cases.

We must not lose sight of the fact that the upper portion of the rectum as well as the colon will easily bear much higher temperatures than the lower part of the rectum, especially the sphincter, therefore, if the injections are given as an ordinary enema, the considerable heat will cause their prompt expulsion.

The administration of gelatin in the form of enema is without danger and free from all disagreeable symptoms. The author has carefully watched the action of the gelatin on the kidneys and has never found any harmful influence. He recalls that gelatin was introduced into dietetic therapy of gastric ulcer by Professor Senator more than thirty years ago, and that it has recently been recommended again for the purpose of nutrition in persons suffering with chronic colitis, for the treatment of hemorrhage in typhoid fever, and in other conditions.

As an explanation of the favorable action of high enemata of gelatin, the author says that, for one thing, the high temperature undoubtedly forms an important curative factor, but this cannot be alone held accountable for the results. It is probable that the content of calcium of gelatin, as well as the mechanical protection which the substance affords to the inflamed mucosa against the irritating contents of the intestine, are to be considered as partly responsible for the favorable results.

#### "ASSIMILABILITY OF VARIOUS FORMS OF IRON

Schirokauer has made some experiments concerning iron metabolism, in Senator's Polyclinic in Berlin, which are reviewed in *Therapeutische Monatshefte* for March, 1910, his experimental subjects being dogs with gastric fistulae and a child with an esophagus-stomach fistula. The best-known organic iron preparations were tested. They were introduced into the stomach and then removed after a while and tested with potassium ferrocyanide. It was found that all iron preparations, without exception, gave off ionized iron under the influence of the hydrochloric acid of the gastric juice. -It

would therefore practically be a matter of no account which kind of iron preparation is given, in so far as we may wish to obtain the effect of iron, but the organic preparations are to be preferred, because from them the chloride of iron is formed more slowly and in smaller amounts, so that there occurs less irritation and hence they are better tolerated by the stomach.

#### ROSENFELD'S TREATMENT OF OBESITY

Rosenfeld's treatment of obesity by regulation of the diet is reviewed in the *Therapeutische Monatshefte* for March, 1910. It consists in the copious ingestion of cold water, tea and thin soups, in order to fill the stomach. Small, frequent meals and rest in bed are preferable to large and infrequent meals and to strenuous exercise, since they exert less stimulating action on the appetite. Rosenfeld makes free use of potatoes and of vegetables which fill up the stomach and yet have only slight caloric value. He does not limit his treatment to fixed "courses," but advocates it as a regular mode of living to be followed continuously, claiming that it will produce a daily reduction of from 250 to 300 Grams. Larger losses in weight depend upon the withdrawal of water. The method has the advantage of obviating unfavorable by-effects, especially nervousness.

All of which is of value. In practice the physician will find it worth while to resort to suitable supplementary drugs. Free elimination with laxative salines, guarded doses of thyroid, and such remedies as colchicine, berberine, apocynin, alnuin and phytolaccin, will prove of value.

#### OBESITY AND A VEGETABLE DIET

Prof. A. Albu of Berlin has employed a coarse vegetable diet, which contains large amounts of foodstuffs that are heavy and difficult of digestion, for the treatment of obesity, trying this method in twenty-nine cases for the purpose of reducing the surplus of fat. The idea is that the stomach be filled with a considerable amount of food-

stuff presenting a large volume, but of relatively small caloric content. Under such conditions about half of the ordinary number of calories, i. e., from twelve to fifteen hundred, were found to suffice as a rule. At first a rapid diminution in weight occurred, without any resulting serious symptoms, however, and these soon ceased.

It is important, in order to obtain good results, that the food shall not be administered in the form of mush. Once or twice during the week two hundred Grams of peas, beans or lentils may be eaten, but not in the form of porridge. Otherwise cereals and leguminous foodstuffs are not permitted, on account of their relatively high food value. Besides bread, vegetables, preserves and raw foods must form the principal amount of the diet, which may also contain potatoes, especially if boiled in their jackets. For bread, the coarse graham bread is most serviceable because of its being difficult of digestion. Drinks like coffee, tea, bouillon, water, lemonade, buttermilk contribute to fill the stomach. They must be avoided during meals if they stimulate the appetite.

Good permanent results are best obtained if the diminution in weight occurs as evenly as possible. A course of treatment in which not too high weekly reductions in weight occur can be continued for some time, and thus a considerable reduction in weight may be obtained, although this does not necessarily have to be proportionate to the degree of the obesity.

The author refers to the small amount of proteids in his regimen. It contains from forty to fifty Grams, not more than sixty to sixty-five, and he expresses his doubts as to the correctness of attributing too much value to the loss in proteid, for, after all, this becomes irrelevant on the copious ingestion of carbohydrates, which tend to save proteid loss. With a daily amount of carbohydrates of 250 to 300 Grams the vegetable diet surpasses the treatment of Dr. Ortel. As for the fat permitted, Albus' method stands between the extremes of the methods hitherto in vogue. Of these the potato diet, with which meat is also

given, contains more proteid from 20 to 30 percent. If treatment is carefully regulated and the menu intelligently modified, the course can be passed through without trouble and complicating features and without any harm to health, nor are these to be feared after termination of the treatment.

Physical exercise and hydriatic procedures may of course be undertaken at the same time, but are not essential. After from four to six weeks, on some days 150 to 200 Grams of boiled beef was added to the bill of fare and finally it was permitted daily; in this manner the reduction in weight was soon arrested. Such a mixed diet, with little meat, can be carried through for a long period without trouble and without an increase of fat which, if it does occur, can be removed by courses of vegetable diet lasting from four to six weeks. Not only obesity but constitutional adiposity are influenced, although the latter not as promptly.

Complications of obesity, especially fatty heart and digestive disturbances, contraindicate this method, which the author illustrates in detail by numerous statistics.  
(Reviewed in *Therap. Monatsh.*, Feb., 1910.)

#### VALUE OF VERATRUM VIRIDE

In *The Lancet-Clinic* Dr. Landis says that eighteen years of clinical experience with veratrum viride, under a constantly widening variety of physiological conditions, has led him to regard it as the most valuable single therapeutic resource at his command. Its value lies in its power as an eliminant; and when we consider that elimination in strictly medical cases is of the same enormous importance that drainage is to surgery, veratrine cannot be overestimated. Nor can we overlook its power to overcome sthenic states and thereby actually to abort or modify in a favorable way acute inflammatory conditions, no less than its power as an antispasmodic. Possibly it increases the normal resistance or acts as an antidote to toxins. Possibly it works through the vaso-motors, restoring to their normal inflammatory areas where the vasomotor control has been lost. In these conditions of acute

inflammation with high fever, rapid, full pulse and impending or actual delirium, its action is little less than magical.

In the discussion following the reading of this paper Herman said: "The Pharmacopeia authorized the use of either white or green veratrum. The white contains poisonous alkaloids, the green does not."

Fitch said that veratrum viride, aconite and nitroglycerin are used to reduce the rapidity and control the blood pressure in the vessels. Aconite, the most dangerous, acts on the heart-muscles directly, while the advantage of veratrum viride is that it acts centrally by paralyzing the vasoconstrictor nerves, but does not affect the heart *per se*. Nitroglycerin acts by paralyzing the peripheral vasoconstrictor nerves, causing dilatation of peripheral vessels. Of the three, veratrum gives the best results.

Dr. Heyn detailed the clinical tests made in the wards of the Cincinnati Hospital. These showed that veratrum promptly reduced blood pressure within six hours, often much sooner. Norwood's tincture was the form used. After the administration was discontinued the blood-pressure rose within a few hours and was often normal within twenty-four to thirty-six hours. No untoward effects resulted. The cases tested were normal, as well as some of arteriosclerosis, hypertension of unknown origin, chronic nephritis, and frequently a combination of heart and kidney cases.

Gillespie described the action of veratrum in a chronic convulsion of a child a week old. In two minutes the spasm was relaxed and in a few minutes more it began to vomit, had a slow pulse and sighing respiration, and in spite of total suppression of urine for more than twenty-four hours the child was alive and well. He asked what other drug or combination of drugs in or out of the Pharmacopeia would produce such results. "These children have a feeble pulse, cold surface and high internal temperature, and I never saw one recover until I began to use veratrum. In cases of any acute toxemia, it should be given in sufficient dose to produce immediate effects. Given thus, it is the greatest life-saver we possess."



## The Need of Studying Senility

V.

Before answering the question What is death? would it not be useful to have a definite conception of the life of the living being, and ought we not first to analyze succinctly the primordial characteristics of living matter? A few words must suffice here.

The essential characteristic of living matter is its *instability*. It is by this that it is most distinguished from inorganic matter. I will not enter into a summary exposition of the different appearances which may be shown to exist between matter called dead [*brute*] and living matter. Biology and physiology have occasion to change daily the lines of demarcation between these two states of matter; in Sabatier's book you can read with profit of the arguments for the assimilation of these two forms of being. Be this as it may, the apparent immutability of crude matter is certainly the opposite of the instability of that matter which we call living, and this constitutes a principal difference between the two.

In what does this instability consist? Its manifestations are many, and in some sort they make up the attributes of living matter. They are irritability, motility, the faculty of exchange with matter exterior to itself, and, lastly, the faculty of reproduction, which last is the most marked characteristic of living matter. We know, in fact, that under the influence of particular affinities, or of external agents, the constituent elements of certain bodies may unite and form these bodies without the necessary

prior presence of any fragment of the resulting body. Never will any fragment of this body determine the production of that body. On the contrary, living matter may cause the appearance of elements, either directly, when they are free, or indirectly, when they are united in more complex combinations, which are necessary to the making of a new mass of living matter, identical with itself, sometimes even better endowed than it is, providing the external media favor, by providing an abundant supply of the various component parts. But the presence of a particle of living matter is absolutely indispensable when an altogether new formation of living matter is to be produced; and this formation is the resultant of actions exercised by that alluring living particle on the medium that surrounds it, which living particle is the only one capable of determining the movement of the elements into integration in the surrounding medium, with the object of constituting a new particle of living matter. This part which the alluring particle of matter plays on the surrounding agents is, according to Sabatier, of capital importance in the existence of living matter. He goes so far as to say that the protoplasm plays this part *necessarily*. This is the recognition in the protoplasm of an intrinsic property, this is to make of it "the characteristic of living matter, since without this action the protoplasm can not find, for the purpose of growth or repair, a protoplasm already formed which it can appropriate."

There is more than mere ingenuity in this interpretation of the nutrition-phenomena,

and if, on first view, this conception of the alluring power (*pouvoir d' amorce*) of living matter seems to be confounded with the function of assimilation, yet a more profound study will show all the happy consequences which this interpretation may have for a more intimate knowledge of vital phenomena generally. It seems to me that in this manner of conceiving and interpreting the means by which living matter repairs itself there is more than the mere find of a happy word, and that it would be a mistake to see in this expression a mere new synonym for the words "assimilation" or "nutrition." We have to understand the sense of the word "allure," (*amorce*), and comprehend in it "a movement capable of provoking a similar movement in a similar medium." This is the interpretation we must give to this term, and it is thus that we shall comprehend it whenever we shall speak of the "alluring power" (*pouvoir d' amorce*). It is by this alluring power that we came to figure to ourselves, easily, all the *moments* in the life of living matter; it is by this that we interpret all the movements of integration, constitution and repair. On the other hand, the movements of disintegration, division and destruction tend above all to a diminution of this alluring power. We are bound to regard this alluring power as playing the first and principal part in the maintenance of life, since it is by it that life can create living matter for itself; by it, also, can living matter nourish itself, can develop itself and give birth by itself to other portions of living matter.

We come back now to the question that concerns us: Why does living matter die? We shall see this by studying *how* it dies.

Life is nothing but a constant transformation of matter, and we can say that life is everywhere. From a general point of view we might deny death and consider it as not existing. But we have confined our study to living matter alone, to which we have given characteristics which limit it, which circumscribe it, which individualize it in a series of bodies of variable but definite form. When these characteristics become lost or are transformed, then it is no longer

living matter. This will always be alive, but the living matter, in respect to its proper individuality, will have disappeared, and we shall say then that it is dead. Death therefore does exist. We might define the death of living matter by saying that it is "the loss of the characteristics of living matter."

To the question, Why does living matter die? the answer may prove to be full of difficulties. For it seems at first view that all the conditions conspired to promise its immortality. So it possesses a great alluring power, and its instability permits its bending to every exigency of the surrounding medium, and its exterior medium is an inexhaustible mine from which it can draw the elements it needs at discretion. We ought therefore to suppose that as long as it rests in the state of simple living matter that there would be no reason why its characteristics should undergo any modification, and, as Sabatier says, "potential immortality was assured to it, or in other words, it was bound to remain protected against natural death." It is evident, however, that the expression "immortality" must not be taken here in the transcendental sense of the word, which would be synonymous with "immutability." What would then be the value of this term? If nothing can change, if all the elements have to be immutable in their relation to each other, would this not be the loss of their instability and of their alluring power, the two principal characteristics of living matter? Would this not be immutability precisely, the grand characteristic of crude, or nonliving matter? This would be negating the circulation of matter, which is an essential part of physiologic life; and this would be the suppression of living matter, as Sabatier says. What we are concerned alone about here is primordial living matter, which is of a fixity that persists in spite of the incessant partial modifications which are the very essence of life. This living matter takes from the surrounding matter around it substances in one form which it returns in another form, keeping up thus the circulation of matter which it needs to compensate the losses it has undergone in the

act of functioning, and in order to remain continuously identical with itself. These detail mutations in the living matter, which we consider, are certainly but small compared with the mass and are effected only little by little, so that it would be impossible to say which parts are renewed, in what quantities and at precisely what moment. These parts become immediately integral parts of the mass of which they take the qualities, habits and tendencies, identifying themselves with it and permitting it to continue itself without there being any interruption, so that there may be continuity and identity. It is therefore in this sense that we are to allow the use of the expression of "immortality" of the primitive living matter. Once, therefore, it is established that living matter ought to remain eternally identical with itself, so long as the external gives satisfaction to its alluring power and for this reason it would seem that death should be avoided.

(*To be continued.*)

#### RECOGNIZING THE PRINCIPAL ALKALOIDS

In the eighties of the last century Robert communicated a very simple means for verifying the presence of divers alkaloids.

Place in a porcelain dish an equally small quantity of a mixture of the suspected alkaloid and cane sugar. Drop a few drops of sulphuric acid on the mixture and notice the immediate development of color, which varies with the different alkaloids.

*Morphine hydrochloride* gives a rose color which passes into violet.

*Quinine sulphate* gives at first a greenish color, then yellow, and finally a coffee color.

*Atropine* gives a violet color.

*Strychnine* gives a yellow color.

*Narcotine* gives a mahogany color.

*Veratrine* gives a green color.

*Codeine* gives first a cherry, then a violet color.

In replacing the cane sugar with milk sugar the reaction does not take place.

We have verified (says the writer, Dr. O. Castro) some of the reactions mentioned and found them just as mentioned above.

It is, however, to be remembered that some of those reactions will occur when sulphuric acid is added to cane sugar, without any alkaloid.

He also found that the sugar of milk with which the dosimetric granules are made up neither hinders nor complicates the characteristic reactions mentioned.

For all that, the method is an excellent one for a rapid demonstration of the presence of the active plant substances.—Castro, in the *Reperoire Universel de Medecine Dosimetric*, Paris et Ghent, 1881.

[Of course the reader will understand that these are not sufficient tests for the purity or strength of substances containing these alkaloids. The task of identification and analysis is not an easy one, even for the skilled chemist.—GLEANER.]

#### ADRENALIN HYPODERMICALLY AD- MINISTERED

Eckert reports the treatment of the sinking of blood pressure in diphtheria with hypodermic administration of adrenalin, in the Universitiy Clinic of Berlin. The adrenalin used was that of the Hoechst Farbwerke, which represents a one-tenth percent solution of suprarenin hydrochloride. From three to four times daily two to three cubic centimeters were given hypodermically. This treatment raised the blood pressure so that it could be measured even after sinking so low that it could not be measured any more. The greatest effect of the injection was noticed one to two hours after administration, and lasted seven hours.

The injections were painful, but cold compresses soon relieved this. A short time after the injection there appeared a local anemia in an area about as large as the palm of the hand and which was surrounded by a slightly pink margin. This anemic spot, which often lasted for hours, is due, perhaps, to the slow absorption of the remedy, and it is this prolonged duration of its effect that makes it so valuable. Infiltrations, abscesses or gangrene never occurred.

No ill effects on the kidneys were noticed. Excretion of sugar was noticed in greatest

amount one or two hours after the injection, the sugar disappearing entirely after fourteen hours. This sugar excretion is not to be regarded as harmful, since the advantages of the adrenalin effect outweigh it. According to Eckert, adrenalin in large hypodermic doses is an effectual remedy for overcoming reduction of blood pressure in diphtheria. It can be administered for a long time, and it does not fail even in the severest forms of intoxication.—*Therap. Monatsh.*, Aug., 1909; in *Pharm. Zentralh.*, 1910, p. 56.

#### FIBROLYSIN IN MIDDLE-EAR DEAFNESS

J. Gay French reports, in *The Lancet* of July 24, 1909, on the use of fibrolysin in 52 cases of deafness with tinnitus which were treated with fibrolysin. Of these 16 were essentially improved, i. e., they heard better and the tinnitus was more or less diminished. In 14 cases the tinnitus was diminished but the hearing not improved. In 15 cases there was no improvement at all. In the cases without suppuration improvement was more frequent than in those with suppuration, but in the latter treatment should be begun as soon as possible after the suppuration has ceased and cicatricial tissue begins to form. In cases of otosclerosis the treatment with fibrolysin was very unsatisfactory, and of fifteen cases two only were somewhat improved. In one case the treatment had to be discontinued on account of vertigo taking place after the injection.—*Muenchen. Med. Wochenschr.*, 1909, p. 2548.

#### SALPINGITIS WITH BACILLI OF EBERTH

Drs. Galliard and Chaput reported an unusual case of typhoid to the Société Médicale des Hôpitaux, at its meeting in November, 1909. There evidently was, in the case, a lesion of the uterine adnexa antecedently to the typhoid, although not suspected at the time of attack.

A woman, thirty years of age, who denied having had any sickness before admission, on May 28, 1909, to the Lariboisière Hospital, presented symptoms of typhoid fever eight days after its onset. The temperature at

first stood at about 40.2° C., then it rose, with oscillations, to about 39° C., and again fell to 37.3° C. on the twenty-third day. After a temporary relapse on the twenty-fourth day, the patient seemed near convalescence, when on the twenty-sixth day she experienced atrocious attacks of colic with vomiting and meteorism, dyspnea, and facies abdominalis; the pulse beating 160 per minute and the temperature rising to 40.2° C. The authors attributed these symptoms to peritonitis from intestinal perforation and decided upon immediate operation.

After a lumbar anesthesia with 8 centigrams (gr. 1 1-3) of novocain, a median laparotomy was made, when the right fallopian tube was discovered to be tumefied and perforated and emptying pus into the small pelvis. This pus yielded a culture of the Eberth bacillus. The uterus and the right adnexa were removed, the vagina being left wide open and in communication with the peritoneum, without drainage. The patient recovered rapidly.—*Gaz. des Hopitaux*, 1909, p. 1587.

#### A HERMAPHRODITE

At the session of the Berlin Medizinische Gesellschaft, November 28, 1909, Dr. P. Marcuse presented the following case of a hermaphrodite: A child about 10 years old, with long hair and a deep voice. It had labiae, a penis with a glans, pubic hair, uterus and genital glands not demonstrable without abdominal paracentesis, the pelvis decidedly masculine.

Dr. Gottschalk remarked that the penis was not perforated, and cryptorchidism was here not probable. He would declare the child a girl.

Dr. Rothmann said that such cases are traceable to an abnormal development of the hypophysis. He considered the child a boy.

Dr. Marcuse replied that, considering the masculine tendencies of the child, he would advise to train it as a boy but, to register it legally as a girl in order to avoid conflict with the law on homosexuality if in future it should feel itself attracted to the male sex.—*Muenchen. Med. Wochenschr.*, 1909, p. 2499.



## A Homeopathic View—And a Kindly One

**A**S an interested reader of the old CLINIC and its lusty successor, THE AMERICAN JOURNAL OF CLINICAL MEDICINE, I can truthfully say that I find it one of the most helpful journals that I read. I like its enterprise, its hustling strenuousness, its fairness and catholicity. Its editorial tone is sound and stimulating and on the whole liberal. Moreover, its articles are practical, meant for the common run of general practitioners, and so helpful. In some other journals I find too large a proportion of articles on diseases one rarely sees and sometimes has not even heard of! Not so with CLINICAL MEDICINE, whose reading matter, editorial and contributed, is always practical and helpful.

I especially like the breezy freshness, the stimulating spice and the outspoken candor of its hustling editor. Great credit, too, is gladly recognized as due him for the value of his contributions to modern therapeutics, for his forceful pushing of the "clean-out, clean-up and keep-clean" idea, and for his trenchant criticism, not only of therapeutic nihilism and agnosticism, but also of the all too prevalent slip-shod empiricism of much modern teaching. Surely, THE AMERICAN JOURNAL OF CLINICAL MEDICINE, by its persistent and strenuous preaching and teaching, has scored a great advance on the older therapeutics, which even some of its prominent teachers have denominated as a "barbarous jargon," as a "most uncertain and unsatisfactory system," having "neither philosophy nor common sense to commend it to confidence."

The insistence upon, not only a careful diagnosis, but also upon individualizing the case, upon treating the patient rather than the disease, and treating him with "the smallest possible quantity of the best obtainable means to produce a desired therapeutic result," deserves all praise. This sounds quite familiar, however, to some of us who had these principles drilled into us the days when we were attending lectures in the medical college. Still, though no new discovery, we heartily subscribe to these ideas.

We will also gladly admit that the use of the active principles, in small doses, frequently repeated until effect, marks a great advance on the old-fashioned "shotgun" prescription containing half a dozen different drugs, many of them crude or impure or composed largely of worthless ingredients. The little "instruments of precision" are not only convenient, but accurate, compact, and as certain in their action as drugs can be. The advocacy of the active principles, especially when coupled with an insistence upon treating the patient rather than the disease, and treating single symptoms with single remedies, is certainly a far cry from the old-fashioned attempt to find a "specific" for every disease; so that all the doctor had to do was to find a correct name for the disease he was treating in order to prescribe the specific drug for its cure.

So, all honor to the strenuous and enthusiastic editor of CLINICAL MEDICINE for his advocacy of these and other principles which undoubtedly mark an advance along the line of progress of rational therapeutics.

Having thrown these small bouquets at the editor, we feel all the more at liberty now to register a "kick". Not a very hard kick, Doctor, only a mild protest that such a fair-minded, enterprising, catholic-spirited man, who has gone as far as he has, should have stopped just short of the fullest liberality. What do I mean? Simply that the usually liberal and fair-minded editor of CLINICAL MEDICINE has not yet been able entirely to rid himself of the outgrown prejudice against a system of medicine that has been teaching, for many years, some of the very truths which he is now so zealously urging, but happens to be called by a name which, though honorable as any in medical history, seems to be the source of unending bitterness and unreasonable prejudice.

My dear Mr. Editor, one of the reasons why I like you and your able journal is because you are teaching, perhaps unwittingly, much pure homeopathy! Occasionally—however, not often, I'm glad to say—I find a sneer or a sling, even in the editorial pages of CLINICAL MEDICINE, at this now "ancient and honorable" system of medicine, which has probably done more for "rational therapeutics," properly understood, than any other medical principle ever enunciated and which certainly has anticipated many of the principles which you now so strenuously advocate.

I will illustrate what I mean. But first let me answer briefly the criticism of the editor that the great weakness and defect of homeopathy, to which he has never received a satisfactory answer, is that when we "prove" crude drugs, tinctures, etc., we don't know exactly what their true physiological action is, there being so many kinds and strengths of tinctures of the same drug, so many different active principles in them, each with a different action on the body.

Let us concede that this objection is valid, so far as it goes, when applied to tinctures or other forms of crude drugs, *as usually prepared*. The fact remains that drugs carefully prepared, with due precautions as to both material and manufacture, and then systematically "proved" on a sufficient number and variety of healthy individuals, do unquestionably develop, with unfailing regu-

larity, certain characteristic symptoms which may fairly be considered their physiological action. It may not be scientifically exact, but as these keynote symptoms occur so regularly in all provings of the same drug, it is sufficiently accurate for practical purposes. Let us grant that similar careful provings of all the "active principles," tested separately, would be an even greater desideratum and still more accurate. But such careful and extended provings of all the active principles have not yet been made.

Moreover, this objection really holds with reference to the prescribing of more than one of the active principles themselves at the same time; for granted that you may know what the physiological effects of each of, say, four drugs are, given alone, you do not know certainly what the physiological effect of their *combination* may be. You may think that each drug will preserve and develop its own special physiological effect, though given along with other drugs having different properties; but you do not *know* this, with scientific accuracy. So the same objection, if valid, holds with reference to even the alkaloids, when two or more are prescribed, as is usually the case, at the same time.

To return to my contention, however, that CLINICAL MEDICINE, and its editor, is teaching much straight homeopathy, is strenuously urging many principles long taught in this school, and is even claiming as new discoveries many truths first proclaimed long ago by the truly great scientist, Samuel Hahnemann, and his devoted followers.

Let me illustrate: For years past we have heard and read a great deal from the alkaloidal school and its literature of the great virtues of aconite as a febrifuge. This has been widely heralded as a new discovery, a great advance on the older therapeutics. No doubt it is a great advance on the older therapeutics of the dominant school of medicine of, say, thirty years ago. But to whom is the credit due, and who made the discovery? Anybody at all familiar with the history and principles of homeopathy knows that almost from the very birth of this new therapeutic system aconite has been proclaimed and

used as a sheet-anchor in sthenic fevers. Its pathogenesis, as indicated in its provings, develops a perfect picture of sthenic fever—flushed face, rapid, bounding pulse, thirst, restlessness, anxiety—all the usual accompaniments of a frank and acute fever. The homeopathic school has been teaching for a century the very truth that the alkaloidalists have been so loudly and zealously proclaiming as a new discovery. Why not give the credit to whom it is due?

What is true of aconite, or aconitine if you please, is true of many other active principles. *They are prescribed by our alkaloidal brothers on homeopathic indications.* In fact a good homeopathist feels quite at home in reading the alkaloidal literature and the indications for the remedies there given. Very largely the indications are almost identical with those found in standard homeopathic publications for the last fifty years. Aconite, or aconitine, if you prefer, is one of the greatest febrifuges we possess, and a sheet-anchor in the beginning of all acute sthenic fevers. But the alkaloidal school wasn't the first to make this discovery. Their "new discovery" is a *re-discovery* of an old truth first taught by Samuel Hahnemann. And every time our alkaloidal friends prescribe aconitine in small and frequently repeated doses for such fevers they are prescribing homeopathically, whether they recognize it or not.

And so we might go through the whole list. Who taught our alkaloidal confrères the value of bryonia, or bryonin, in inflammations of *serous* membranes? Reading the indications for bryonin in the alkaloidal textbooks, a homeopathic practitioner might think he was reading from a recognized homeopathic *materia medica*, so nearly identical are they. The point is here: bryonin, as prescribed and used by our "active-principle" friends, is prescribed *homeopathically*. The principle on which it's given is homeopathic. Why not give the credit where it is due? Why not recognize that the homeopaths were the first ones to systematically "prove" bryonia, discover its physiological action and point out the indications for its use therapeutically?

(The question of *dose* is entirely a side issue. We heartily believe in "the smallest possible quantity to produce a desired result.")

So it is with many other drugs. The indications for their use, as given in alkaloidal literature, are so nearly identical with those long described in homeopathic textbooks—without any credit being given—that one is sometimes tempted to think they have been transferred bodily. Times without number I find aconitine, atropine, bryonin, berberine, caulophyllin, cicutine, emetine, glonoin, helenin, gelseminine, hydrastine, phytolaccin, sanguinarine, and many other active principles prescribed *on purely homeopathic indications*. We have no quarrel with our alkaloidal friends for doing this—on the contrary, we think them very sensible; but why not give the credit for "proving" these drugs and pointing out the indications for their use *therapeutically* to those pioneers of scientific therapy who first taught these principles? If a drug, tincture, dilution, or active principle, is prescribed homeopathically, why not admit it and recognize the truth of the principle? What's in a name? I care nothing more for a mere name, Mr. Editor, than do you. It's the truth we are after, from whatever source and by whomsoever spoken. Only we like to see fair play and the "square deal," in which we gladly admit the editor of CLINICAL MEDICINE also undoubtedly believes and generally practises. But in this one respect we can't help feeling that he has not yet been wholly set free from the shackles of prejudice.

There, Doctor, I have "talked back" at you at much greater length than I intended, but I don't see how I could have made it shorter and been "delivered" of what was on my mind. The "kick" has been delivered gently and with the greatest admiration of and good will toward you and your work. It is the first time I have been guilty of taking this privilege, and as I said, you yourself invited it!

You have got the two things you say you like above all others: "One is that a man should write and tell the editor he is pleased, and the other that a man should give him a good 'cussing'." Well, we are certainly

pleased with THE AMERICAN JOURNAL OF CLINICAL MEDICINE, its editor, its platform, and its teaching; we have also "cussed" a little at him, perhaps "stepped on his corns," and maybe will get "licked" in return. After all, what does it matter so that we are all honest in our convictions, desiring only to know and act the truth, honestly seeking by the best methods known to us to cure the sick, "*cito, tuto et jucunde,*" and keeping an open mind for new light, a liberal spirit toward our fellow practitioners, and charity for all? And, so, farewell.

CALDWELL MORRISON.

Newark, N. J.

[This letter is so admirable in text and in spirit that we present it word for word, as received from the writer, with an apology for holding it a long time before printing. If all homeopaths had been animated by a similar spirit, there never would have been a separatists school; there would be none now.

In regard to the matter in question, however, the difference between us lies solely in the point of view. Our correspondent, familiar with the application of the remedies which he mentions, as laid down by homeopathic rules, notes that we employ the same remedies for the same indications, and comes to the conclusion that we clipped these indications bodily from homeopathic works. In this he is mistaken. So far as we know, not a solitary indication for the use of a solitary medicine in our list was taken, and certainly not by us, from any homeopathic work. We arrived at the indications we give from observations of the action of these medicines when applied clinically. The first hint for the application may have come from any source whatsoever. Some came from physiologic experimentation, many came from accidental applications of the drug, and it is possible that at second or twenty-second hand some of these indications may have originated with the homeopathist, have wandered into medical literature through devious ways, and when they came to us their original source was totally lost sight of.

But the most important matter is that we, working from the one standpoint, and the homeopathist working from another, a totally different one, should have in so many cases arrived at the same conclusions. This is a proof of the correctness of the work of both, and may well give each more confidence in the conclusions reached by the other.

For ourselves, I believe we are as free from prejudice as it lies in mortal man to be. We have against homeopathy none whatever. Frankly, we do not believe in the application of infinitesimal doses. Nevertheless we are quite aware that our own knowledge does not comprise the universe, and the very remarkable paper presented by Prof. Mays in *The Boston Medical & Surgical Journal*, some time ago, went far to arouse in our minds the suspicion that possibly there might be more in small doses than we ourselves knew. But our own work has been with drugs in ponderable doses, those sufficient to influence the bodily functions in an unmistakable manner.

Our position in regard to homeopathy is the same as it is toward eclecticism. We believe that the day for separate schools is past, that all branches of the profession have so far progressed that the points at issue are not now sufficient to justify separation.

We believe that every homeopathist and eclectic should join the American Medical Association and its branches, retaining his full liberty as to belief and to practice while so doing. Since the head of the American Medical Association is an ex-homeopathist, it certainly looks as if any fears of such affiliation on the part of these gentlemen are trivial and unworthy of consideration.

We believe that every college belonging to these sects should become regular. At the same time we would advise each of the schools to maintain its own organization, in order that the special studies which they have carried on should be continued and developed to the utmost of their possibility for good. Further, we would suggest that in these colleges a chair should be endowed for teaching the special tenets and principles of the school, that that work also should be

kept alive to the utmost possibility of its usefulness.

Were this done, a good deal of the force expended in fighting each other could be diverted to the general defense of the profession at large. Each of these three schools demands of candidates desiring to enter the profession a full four, or more, years' course of medical instruction. Our common enemy is the party who wishes to enter the practice of medicine without such a course of instruction as would fit him to safely practise it; and were the three schools united, our opposition would be much more effective than it is at present. Now, under the wing of the really educated eclectic and homeopathist, a multitude of pretenders ride into legal safety within the ranks of medicine.

This is our individual position. We are well aware that in thus stating it we are occupying the pleasing position of the man who interferes in a fight between husband and wife, and that we are tolerably certain to receive the blows from both parties. The extremists are never willing to concede anything whatever of good to their antagonist. However, the personal matter has never influenced us in the slightest degree. We have endeavored faithfully to do what we hought to be right, and are content with that position.—ED.]

#### DIFFICULTIES IN THE DIAGNOSIS OF SCARLATINA

The consideration of scarlatina in the September number of CLINICAL MEDICINE fairly covers simple, uncomplicated cases of the disease as seen in private practice.

The real danger, however, lies chiefly in the complications and sequelae. The most important of these are otitis and acute nephritis. To the first of these a large proportion of the deaf and dumb may ascribe their misfortunes; the second often steals upon the victim so insidiously that life is not infrequently sacrificed. They will occur under the best-known treatment, but even so, there is no excuse for any neglect on the part of the attending physician.

When scarlatina makes its appearance in private families, there is no need of undue haste in reaching a definite diagnosis. If not positive on the first visit, or the first day, a delay of a day or two will work no great harm. But when the disease appears in institutions where there is a large number of children, the problem of diagnosis may become a decidedly difficult one; and here it is essential that the diagnosis be made promptly and correctly.

Some observations upon a recent outbreak in an institution in this city will probably best illustrate my meaning.

In the home in question are housed some 350 children, from two to twelve years of age, about equally divided between the sexes. In passing, I may say that I have looked after the children of this home every alternate month for more than thirty-seven years. In all that time we have had but a single epidemic of scarlatina, which was about twenty-five years ago, when we had seventy or eighty cases, but none terminating in death.

In the latter part of June last a number of these children attended a picnic with children from a church Sunday school. A violent storm arose, and all the children, wet and perspiring, were huddled together in a small railroad station. In due time scarlatina, measles and diphtheria developed among the home-children. The promiscuous mingling with outsiders, under the favoring conditions, rendered the contracting of contagion possible if not even probable.

As a result we have had 67 cases of measles, 15 of scarlatina, and 2 of diphtheria. Perhaps I should say one of diphtheria and one of croup. The New York Board of Health considers croup and diphtheria identical. Pathologically it may be so, but surely there is a clinical difference. I have never known a case where true croup was contracted from another person, but, of course, I can not say the same of diphtheria. In this home we have three hospital wards, and three quarantine rooms.

The obvious thing to do was to place the scarlatina patients in one ward, the measles

in another, and doubtful cases in quarantine. Easily said, but not so easily done. If all the cases were typical and the diagnosis instant, the assignment would be easy. But such was not the case.

Suppose that on some morning we find four children ailing with somewhat similar symptoms: fever, headache, gastrointestinal disturbance and indefinite malaise. No positive diagnosis possible. If there be vomiting, we may suspect scarlatina. We look at the roof of the mouth, in front of the uvula, for the earliest eruptions of measles. Rubella may still further complicate diagnosis.

After a day or two our cases clear up. One has scarlatina, one measles, and the other two only gastrointestinal disturbance; but all have been exposed to contagion, necessitating quarantine for two or three weeks longer. If each is assigned to a separate room and day after day new cases appear, with a separate nurse for each, the resources and limitations of any ordinary institution will soon be exhausted. In private families diagnosis can wait; here it cannot. If the two ailing children be sent to their dormitories, there is strong possibility that should they have contracted scarlatina or measles, they will expose numbers of their associates. So, the further we proceed, the more complicated the problem of segregation becomes.

It might be supposed that charts of skin diseases, published at considerable cost, might be of some service. But they give only typical forms of eruptive diseases concerning which no tyro in medicine need be at fault. It is the atypical, irregular forms that are puzzling. These are not imaginary situations. They have occurred and will occur whenever two or more contagious & eruptive diseases invade large institutions at the same time.

Those of limited experience may think that there should be no great difficulty in distinguishing scarlatina from measles. It should be remembered that a little more than one hundred years ago the two diseases were not differentiated but were classed as one—measles.

William Moss, surgeon, in his essay on the diseases of children published in London, in 1781, devotes some fourteen pages to measles, but says not a word about scarlet-fever. A few years later the impression gained ground that there was a form of measles differing essentially from the accepted type. Some textbooks devoted a few lines only to this peculiar form, which was termed "the scarlet fever."

How difficult, if not impossible, it is to make an off-hand diagnosis, may be illustrated by a single case.

A boy nine years old was seen by my associate, Dr. Roger Durham, and his trouble diagnosed as measles. This was confirmed by the chief diagnostician of the Health Department. The boy was sent to the measles-ward. A few days later the symptoms were indicative of scarlatina. The complications and the most pronounced and prolonged desquamation showed that it was an undoubted case of scarlatina. Then all the children in the measles-ward were exposed directly to this case of scarlatina, as well as indirectly through the attending nurses. There were three cases with a similar history.

And right here arises an important question. Is it possible for a child to have both scarlatina and measles at the same time? As the result of somewhat extended observation, I am of the opinion that the two diseases may occur *pari passu* in the same child, and that the sequela of the two may sometimes be clearly discerned.

BENJAMIN EDSON.

Brooklyn, N. Y.

[Dr. Edson certainly raises an interesting question, in the last paragraph of his interesting paper, a question which some of our readers may be able to answer.—ED.]

#### POTASSIUM PERMANGANATE AND OTHER REMEDIES FOR IVY POISON

On page 1011 of the September CLINICAL MEDICINE I notice that for ivy poisoning Dr. Turman recommends very highly a local application of spirit of nitrous ether.

A remedy far ahead of this and very well known to most physicians is a solution of potassium permanganate applied locally to the affected parts. This preparation, as we know, is an antidote to snake bites and the bites and stings of various venomous insects and reptiles, as well as to morphine and other vegetable poisons. I don't believe there is any drug that is superior or even equal to a solution of potassium permanganate as a local application in cases of rhus poisoning.

Recently the local application of quinine sulphate has been recommended as a specific for rhus poisoning, but it does not give good results in my cases. I find a solution of salicylic acid in glycerin and water, or a bichloride of mercury solution applied locally, far superior to the applications of quinine or spirit of nitrous ether.

JOHN ALBERT BURNETT.

Gans, Okla.

#### RHUS POISONING: STUBBORN CASE CURED WITH QUININE

Contact with either poison-ivy or poison-sumac caused, at first, slight redness on the forehead where the hatband rubbed, gradually extending to hands and arms and then to the face, and finally to practically all over the body. Itching was intense—so much so that opiates had to be used to make it endurable. Internal medication consisted of calomel, podophyllin and bilein, followed the next morning with a laxative saline flush. Echinacea was taken during the entire course of the attack.

The following remedies were employed externally without the slightest benefit in any way, shape or form: spirit of nitrous ether, lead acetate in alcohol, copper sulphate, sodium hyposulphite, echinacea, grindelia, beside several others. The solutions were applied freely, faithfully, continuously, and as scientifically as possible, but without affording the slightest relief, the condition, on the contrary, gradually becoming worse. Itching continued very severe; nerve reaction almost to the point of nervous prostration.

As a last resort, a solution of quinine sulphate, in the proportion of 1 ounce to 8 ounces of water, applied locally, was found to be the treatment necessary. Within five minutes after the first application the patient fell into a sleep and had the first rest possible to secure in eight days, a complete cure quickly resulting. The affected skin, it may be stated, very soon took on a dry appearance followed by abundant exfoliation.

This quinine treatment is certainly to be recommended, at least after the ordinary treatments seem to be wholly without any value.

C. W. CASPER.

Marshall, Mich.

[The literature on the treatment of dermatitis venenata is as extensive as it is contradictory, and the two foregoing interesting and welcome communications are no exception to the rule of disagreement. Seemingly there are involved factors that require more careful investigation and differentiation, such, for instance, as the particular species of venomous plant involved, the age and condition of the individual affected, the treatments tried before the physician is consulted, and most important, perhaps, the stage in which a given agent is being employed, a given remedy being conceivably helpful only at some particular period, while, possibly, even positively harmful at another.

One thing seems certain: inasmuch as the peculiar venenos principle of the plants is now agreed to be an alcohol-soluble fatty body (toxicodendrol) closely allied to the acrid cardol, the mechanical removal of this offending substance is the first and most rational indication. This is where alcoholic solutions, spirit of nitrous ether, as possibly also alkaline lotions, come into play; only that it is not enough (maybe even directly harmful by spreading the poison) merely to cover the inflamed portions with the lotion, but the skin must carefully be rubbed or wiped off with frequently renewed wads of cotton wet with the solvent. This probably is where every experimenter thus far has sinned.

In this light we also see how the noxious irritant may be conveyed, by fingers and dressings, all over the body. Remembering the fatty nature of toxicodendrol, it also becomes plain that the poison is not wafted about by the breezes but must be conveyed direct or else by contact with person or articles that rubbed against the plant—this affording a rational explanation of the case, some time ago reported in these columns, where a man was sure he had twice suffered ivy poisoning by skinning hares, the latter presumably (granting the diagnosis) having lain on the poison-shrub, the venom adhering to their pelts.

While the season, at least in the northerly latitudes, is past, a few of the more promising, but not so often named, remedies may briefly be called to mind in this connection, for future reference, viz.:

Hydrogen-peroxide solution; as a first measure, to sponge off the skin, preferably after an alcohol wash. Then dress with carbolized magnesium-sulphate solution. Guaiacol is sedative and anti-inflammatory. Calcium sulphide in strong solution; and also internally. Black wash, yellow wash, and some recommend a weak solution of mercuric chloride, frequently daubed on for a few minutes at a time. For the later stages some advise thymol iodide, ichthyol, or the latter in combination with resorcin and petrolatum. Finally, we quote Dr. M. E. Johnson of Pittsburg, who says the following will cure every time, be the victim a socialist or Christian scientist, maharaja, clubfoot, reformed Fletcherite, or what you will. This is the magic arcanum:

"A strong solution of sodium salicylate, borax, fluid extract of hydrastis in water, used in a wash twice a day and followed each time with an ointment composed of acetanilid and white petrolatum applied freely will promptly cure every case of ivy poisoning."

In conclusion it may be stated that a symposium on this subject, to which thirty-two physicians contributed, appeared in "American Alkalometry," volume iii (1900-1901), page 657 *et seq.*, a few bound copies of which can yet be supplied. Price \$2.00

each, or \$7.00 for the four of the series.—  
ED.]

#### FOR EARACHE

There are formulas without number—books of them—but one tried and proven by years of use is worth a hundred taken at random. Every doctor has a favorite or two, possibly evolved from experience or maybe handed down by a preceptor or a father, be it for an ointment, a liniment, a pill, a throat swab, a toilet preparation, or something else.

Here is a useful one for earache. Glycerin is far better for the ear than an oil, being more penetrating and, quite important, easily washed out:

Menthol .....	grs. 20
Camphor .....	grs. 20
Phenol .....	gtts. 15
Glycerin .....	oz. 1

Label: Warm ten drops in a spoon and pour into ear.

S. H. SNOW.

Washington, Kan.

#### WHO MAKES YOUR MEDICINE? AN ANSWER

Every physician in this country should read the leaflet of the N. A. R. D., reproduced on page 991 (October issue) of this journal. It is worthy of consideration, since it is such an insult to the skill and intelligence of the medical men. It is to be hoped that someone will give a public reply that will end this sort of work on the part of some few of an honorable set of men. Meanwhile, the thoughts that came to me on reading this article may be of service to others who may be asked questions by patients and friends.

*Danger of taking medicines not made by experienced druggists.*—If this is a real danger, why do the druggists not make the medicines which they sell? Why do they buy their fluid extracts from the manufacturing houses and prepare tinctures and other galenicals from them? If it is wrong for the physician to dispense medicines

that he buys, it is certainly wrong for the druggist to do the same thing. The mixing of ready-prepared drugs can not be construed to mean the making of a medicine.

*Physicians not fitted to give medicine.*—Can anyone show, to a fair-minded judge, why the person who writes the directions for compounding a medicine is not as competent to carry out his own directions as anyone else? I think not.

The statement is made that this power should never have been given to the profession. The writer of the leaflet must know as well as we do that this power never has been *given* to the profession—it has always belonged to it. Our early predecessors gathered the herbs, dried them, and made their own preparations. Later they employed assistants who did this work under the immediate supervision of the physician himself. It is from these assistants that the druggists are descended. Now they are arrogating as a right that which was given to them merely as a matter of convenience; and they are now assuming to dictate to the ones who must be the judges, not only what they shall use, but how they shall use it.

*You get poor medicine.*—Of course the druggist never uses inferior drugs! Of course he never buys in bulk from the wholesaler, taking just what may be sent, and that usually the cheapest! Of course he never uses any preparation without testing it for strength and purity! Of course he never buys from any but reliable houses! Of course, when offered two similar articles, he never takes the cheaper! Of course he never considers the amount of money to be made! But since the druggist can not even be suspected of doing these things, there is nothing to be said under this head.

*The druggist sure to correct physician's mistake.*—The druggist never makes mistakes—of course not. The prescription read:

Atropini sulphatis .....grs. 2  
Aqua dest., q. s. ad. ....oz. 1

Since mistakes are never made by drugists, we must conclude that "Aqua dest." signifies alcohol; how else could alcohol

have been used in place of water, causing considerable pain to the patient who had been instructed to drop the solution into his eyes? Of course it was not a mistake when the druggist pasted the eye-drop label on a small bottle of medicine intended for a weak stomach, and handed it to the oculist's patient. I have never heard what became of the atropine solution.

The public is called upon to decide to whom its patronage is to be given. It seems to be making its decision, and this decision is in the favor of the physician who supplies medicine at the instant needed and against the men who write prescriptions, for which the patient must often go some distance and pay a round price.

In this connection some other things naturally come to mind. For instance: A certain druggist examined the urine of a man who was under treatment at the time and told him that it contained five percent of sugar. The druggist also recommended that the man give up his physician and take some medicine which he would prepare. The peculiar part of this is that a careful examination of the urine, by the physician and by a chemist (not a druggist), failed to show the slightest trace of sugar.

I would like to call the attention of the writer of this leaflet, and of those who circulate it, to an old saying: He who lives in a glass house should pull down the blinds.

In conclusion, I wish to add that nothing I have said is intended to reflect on the druggists of the town in which I am located. They are a fine set of men, and, so far as I know, are dealing squarely with the doctors.

C. O. SOUTHDARD.

Berkeley, Cal.

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#### "SOME DOCTORS OF FICTION"

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I am sure that there will be thousands of readers of the medical journals who will be pleased to welcome Dr. George Thomas Palmer, formerly editor of *The Chicago Clinic and Pure Water Journal*, back into the family of medical writers. He has prepared a series of articles on "Some Doctors of Fiction," which will appear from month

to month in *The Medical Brief*, beginning with the issue of October, 1910. Those of us who have already had a taste of his work, in the old *Chicago Clinic*, in which a couple of years ago he gave a discerning, witty and thoroughly interesting essay or two on some of these "doctors of fiction," will be prepared for a feast. We congratulate the *Brief* on securing this series. We shall hope to see it ultimately in book form.

The *Brief* is growing better all the time. Dr. Atkinson has breathed into it a living personality. It is now as scholarly as it is interesting; and it is the best evidence of the skill of the new editor that he has made it scholarly without taking out of it the human interest which was so characteristic of it in the old Lawrence days. *Crescat!*

#### DR. BETTERMAN'S "LETTERS"

I have read with pleasure your warm editorial on "The Letters of Old Dr. Betterman," in your September issue.

These letters, which have appeared serially in *The Office Practitioner* during the past year, have elicited so much favorable comment, and so many requests for the entire set, that I have arranged with the author, Dr. C. E. Blanchard, to publish them in book form.

In order to "round them out" several "Letters" have been added to those which have already appeared, together with an introduction and a chapter on the closing scenes of the life of that unique type of the old-school physician so beautifully portrayed in the character and writings of Dr. Betterman.

The book is now in press and will be ready for delivery about October 10. A popular edition, in art-poster binding, will sell at 75 cents per copy; a de luxe edition, in leather binding, will sell at \$1.25. Details will be given later.

In view of your favorable opinion of these "Letters," I believe you will be glad to make this announcement to your many readers.

J. D. ALBRIGHT.

Philadelphia, Pa.

[We print our friend Albright's letter just as received, believing that it will explain our position in the matter quite as well as anything we might say. We shall be pleased to receive orders for this book any time, delivery to be made as soon as we receive our first shipment. We predict a large sale for it, as it surely deserves.—ED.]

#### THE LATEST HEALTH FAD!!!

During the last few months there has been a noticeable lack of new and startling discoveries for the radical cure of our physical ailments. No new Elijah, with healing in his wings or voice, has proclaimed his magical and miraculous power over disease, death and the grave. No retired clergyman or returned missionary from the Cannibal Islands or the Modoc Indians has announced any new secret discovery of a concoction of roots and herbs and rattlesnake fangs, warranted to restore to us the pristine vigor of the native aborigines, Dowieism, Schraderism and like isms by the score, including the semiethical Emmanuel Movement, have gone into President Cleveland's "innocuous desuetude." Even Peruna has failed to compass the full intentment of its preposterous claims and predictions. Wonderful cure-alls and marvelous discoveries have lost their savor, their virtues and their potency, and are being sold at "cut-rate" at the drug-stores and for five cents at public auctions.

Thus the dear afflicted people with their cultivated appetites and abnormal cravings for the flesh-pots of Egypt, for sensational supernatural cures, in their distress and extremity and utter demoralization are demanding relief and succor, and in order to find it are chasing and hiking hither and yon after that delusive *ignis fatuus*, the vanishing mirage called "health," from the rivers to the end of the earth, and from Dan to Beersheba, unmindful of the fact that

Health's too much for mortal quiz,  
Pulseless sage or saint;  
The very place you'd swear it is  
That's the place it ain't.  
Folks from Maine to Texas go  
Hunting it in vain;  
Texans looking for its glow  
Hustle back to Maine.

Thus the dear people, perishing from therapeutic nihilism, famishing on suggestive therapeutics, and dying from imaginary diseases voice an irresistible appeal, a universal demand, that this unsatiable thirst, this aching void, be filled. But by whom? and by what? By the unscrupulous mercenary nostrum vender who would grow rich upon their afflictions? Not on your life!

As a humble member of the medical profession, the ultimate aim of which has ever been the eradication of disease and suffering and the protection of the people, I can announce with pleasure and confidence that there is still a balm in Gilead, that there is a safe and sane, a rational, substantial and purely ethical health restorer, a product of nature's own laboratory, rural, urban and cosmopolitan.

A decoction or tea made from the alfalfa plant, properly seasoned with cream and sugar, or, if preferred, a little lemon, and taken by the small glassful during the day at regular intervals, is the most nourishing, nerve-building, fat-producing, muscle-strengthening, in fact, the most refreshing product of the *materia medica*. It is said to be mildly laxative, an aid to digestion and a great blood producer. Here is a remedy that has successfully passed the stage of empiricism and has stood the most critical and searching test upon the lower animals ever conducted; and when it came to the supreme clinical test—impartial and thorough—its glory was not diminished or its virtues beclouded. Testimonies as to its virtues come not from fictitious pictures or more unscrupulous statements, but from the whole family of lower animals that have been fed and nourished upon it. You cannot help but admire the fat, sleek and healthy prancing horse, the corpulent cow, or close your ears to the satisfied and contented grunt of the hog, too fat and lazy to rise from feasting upon this succulent food while her numerous offspring, chubby dumplings that they are, gambol about her in the enjoyment of supreme health and happiness. These are testimonies that cannot be gainsaid.

¶ Oh, ye poor, skinny spinster, quaff this elixir and become robust, rotund and rosy.

And you, ye health chasers, who have lost your health in Ohio and are foolishly and vainly searching for it in California, use a little of the twentieth-century revised version of Christian science, get an Emmanuel movement upon you, hustle back to the place you lost it, and hike away to the alfalfa fields (barefooted if you will) and partake of this exhilarating protein compound, the beverage that cheers but will not inebriate. Get its sunshine in your soul, its radiance in your heart, its bloom upon your cheek, its sparkle in your eye, and its elastic spring in your step.

You don't have to make a decoction of the advertisements of this remedy and drink them to get results. It is sufficient unto itself. It is pleasant, healthful, harmless, inexpensive; the poor man's friend and the rich man's benefactor. It is precious, plentiful and priceless. It is a life-saver, money-saver, trust-buster.

All flesh is grass. Get back to nature. Emulate the example of your illustrious ancestor, Nebuchadnezzar, and eat grass. And then from out the deeper recesses of your healthy soul and the peaceful melody of your heart you can carol with the birds the joyful refrain—

"Al-fa-la-fa-fa-fa-la!"

DAVID E. SPAHR.

Xenia, Ohio.

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#### FIVE CASES OF PELLAGRA OCCURRING IN ONE FAMILY

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Mrs. C., white, age 31, native of Mississippi; began menstrual period at fourteen years of age; mother of six living children (all girls) history of several miscarriages. Father living, age 77, health good; mother dead in menopause (uterine carcinoma). Removed to Wilson, La., two years ago.

She enjoyed good health until Aug. 18, 1909. Present illness began with malaise, some slight febrile reaction covering several weeks. Oct. 8 she began flooding (menorrhagia or metrorrhagia), which continued interruptedly until Oct. 18. When this was checked amenorrhea followed, which has persisted. March 22, 1910, an erythematous

eruption appeared upon the back of each hand. This was mistaken for sunburn, but within ten days it deepened in color and vesiculated; upon rupture of vesicles a raw base was presented. There was little actual pain, but an intense burning, itching sensation, which upon scratching, rubbing, etc., has caused considerable destruction of tissue. The skin lesion has extended about two and a half inches up the forearm from the wrist.

April 15 the gastrointestinal symptoms, i. e., diarrhea and stomatitis, became pronounced, the bowels moving six or eight times during the night. There is coincident mental involvement, a mixture of idiocy and insanity shown by the characteristic facies, with delusions, hallucinations, etc. The latter are getting more frequent. Cachexia is profound.

Case 2. Aurelia C., age eight and one-half, daughter of the preceding. Previously healthy. None of the diseases of childhood. Eruption first noticed on April 9. Lesion began on feet, extends up leg to the junction of the middle and lower third. Lesion on hands quite marked, but not so pronounced as in Case 1. Gastrointestinal symptoms are absent in this case, probably owing to recent infection.

Case 3. Lillian C., age six and a half. Previously good health. Eruption first noticed about April 1. Lesion on feet and extending to junction of middle and lower third of leg. Eruption on hands not so marked, but plainly visible. Gastrointestinal symptoms absent.

Cases 4 and 5 are in the earliest stages of the disease. Symptoms easily recognized, but not marked as in preceding cases.

With one exception, all of these patients presented unmistakable evidences of the disease. The mother alone presented gastrointestinal and mental symptoms.

We elicited the information that the entire group lived upon cornmeal for prolonged periods, and that the meal was always of an inferior quality, occasionally musty. The possibilities of the transmission of the disease from one to another must be considered. All occupied the same apartment, perhaps the

same bed, used the same washbasin and towel, and were in almost constant and intimate contact. The interval between the appearance of the disease in the mother and its occurrence in the children strengthens the theory of transmission by contagion.

In view of the fact that the etiology of pellagra is still obscure, it seems to us that some definite plan should be inaugurated for the segregation and care of these unfortunates

W. A. KELLOGG  
W. B. SINGLETARY

Wilson, La.

#### HONORS IN THE RIGHT PLACE

We are always glad when a doctor gets the honors which he deserves—especially glad when that doctor happens to be a member of the “family.” We therefore take special pleasure in extending our congratulations to Dr. C. S. Scofield of Richford, Vermont, who has just been elected to the legislature, from his town, by a handsome majority. We advise other doctors to “go and do likewise.”

#### AN EXPERIENCE WITH THE PNEUMONIA OF OLD AGE

Mrs. A., age 72 years, on March 17, after working in a freshly ploughed garden, had a chill followed by high fever, cough, thoracic pain, and dyspnea. The chill lasted about two hours. I saw the patient two hours later and found the following conditions present:

Temperature 104° F., pulse 110, respiration, 32; skin hot and dry; tongue coated; dry hacking cough, she complained of pain in the right side and of headache.

The physical signs were those of an acute bronchitis. The respiratory sounds were harsh, expiration lengthened. The right lung was full of sibilant and sonorous râles, with a few fine crepitations at the base; a few sonorous râles in the left lung.

A diagnosis of acute bronchitis was made and the following treatment instituted: Calomel and podophyllin were given in divided doses, followed by epsom salt to evacuate the bowels freely. Aconitine, atro-

pine, digitalin, and cactin were administered to reduce the fever and control the circulation and the skin sponged with tepid water while cloths wet in ice-water were applied to the head. Emetin, calx iodata and small doses of codeine were employed to facilitate expectoration and relieve the distressing cough and pain in the side. Sulphocarbonates and nuclein were given in appropriate doses.

During the following twenty-four hours the temperature dropped to 100° F., pulse to 90 and respiration to 24. Expectoration became free though slightly blood-stained, and she was free from pain; the bowels were freely open and the general condition greatly improved. I continued emetin and calcidin, and added the arsenates of iron, quinine and strychnine to the nuclein and sulphocarbonates. During the next twelve hours the temperature dropped to normal, the lung became free from râles and the general condition good.

Twelve hours later she had a severe rigor lasting about an hour, with elevation of temperature, a return of the pain in side, dry, distressing cough, and muttering delirium. Upon examination I found both right and left lungs involved in a catarrhal inflammation, the right more so than the left. She was conscious at times, and when so, complained of intense headache, diffuse pain in the right side, and pain across the lumbar region and at the neck of the bladder.

During the next five days the bowels were obstinately constipated and tympanites was marked. On the seventh day of the disease the kidneys were acting very sluggishly, urine high-colored and offensive. Delirium marked, respiration shallow, labored, and at times with a suggestion of the Cheyne-Stokes type. Pulse 110, weak, irregular and intermittent. I was unable to detect the apex-beat at times. During the next three days delirium continued, expectoration was slight and blood-stained, cough distressing, face cyanosed, respirations varying from 40 to 50 a minute; breathing was interfered with by the gaseous distention of the bowels. Pulse varied from 110 to 130, and at times I was unable to detect the radial pulse. Kidneys

acting scantily; incontinence of bladder and bowel.

During the next twenty-four hours there was slight improvement in the general condition. Delirium not so marked, expectoration more free, lungs clearing rapidly. During the next three days gradual improvement in general condition. Mental condition good. Temperature, pulse and respiration resumed their normal condition. Bowels and kidneys acting freely. Free expectoration. Convalescence established about fifteen days after beginning of the pneumonia.

Treatment was as follows: Initial purge of calomel and podophyllin, followed by magnesium sulphate. Sulphocarbonates of zinc, sodium and calcium throughout the course of the disease. Aconitine, strychnine, digitalin and cactin, with tepid water sponges to control temperature. Digitalin, atropine, strychnine and sparteine were given to support the heart. Nuclein, by the mouth throughout, and hypodermically with digitalin. Strychnine, strophanthin and camphorated oil at irregular intervals (when heart showed great distress). Arbutin and barosmin were given for the renal inactivity and with good results. Emetin, calcidin and sanguinarine nitrate were given as expectorants. Tepid water sponges seemed to relieve the delirium better than anything else. Chicken broth, beef extract, albumen water, whisky and egg, given at regular intervals and carefully regulated constituted the chief nourishment.

Convalescence is now well established, the lungs are entirely free from mucus, bowels and kidneys active, mental condition good, and she is gradually regaining her former strength and vigor.

The above case presents, in my opinion, quite an interesting study. The patient developed an acute bronchitis with an abatement of all symptoms, a second chill followed by a catarrhal inflammation of the right lung with a later involvement of the left, attended by active delirium, obstinate constipation and renal inactivity.

Such cases as the one here under consideration used to be the despair of the physician. Today we can hope for better

things—thanks to our modern rational treatment with the alkaloids.

R. K. OGILVIE.

Blodgett, Mo.

#### ACUTE TUBERCULOSIS, OR GALLOPING CONSUMPTION CURED BY BROMINE INHALATION

I first saw Mr. Mack Williams, age 21, from near Jonesboro, Arkansas (a region where consumption is common), on the 18th of June. His history was that three years ago he nearly died of pneumonia and malarial or "bilious" fever and thought he had "never entirely recovered through his chest" although he had "worked as usual and paid little attention to it." Late last fall he weighed 158 pounds—as much as ever in his life. He generally weighs most in winter. He took the grip in April and by about May 1 was too weak and sick to plow and work as he had been doing, and from that time went down till, as he afterward said, he knew he "must die right soon unless something was done."

He started for help and reached Eureka Springs, a stranger, thoroughly exhausted. When I first saw him he seemed to have absolutely given up all hope of recovery, and it is difficult to give you a picture of his stoop-shouldered, woe-begone appearance further than to say that he presented a typical one of advanced consumption. He was emaciated, very weak, there was severe and almost constant cough with most profuse expectoration of bloody mucus, with masses of green "sinkers." He had "sweats" night and day when asleep, and suffered from extreme anorexia; did not eat as much the entire first week as now at one meal.

Physical examination showed good build, weight 121 pounds (which in the next four days dropped to 117—the lowest he got). The entire right lung seemed "shot full" of disease and gave almost the entire range of adventitious sounds, from the metallic tinkle and whistle to the simpler mucous râle. The superior lobe of the left lung proved the most seriously affected; a cavity had formed in its lower border. He was

going graveward "on a gallop." Pulse at first examination was 96, temperature 101° F.

I put him at once on the bromine inhalant, and realizing it was his only show and required quick work I made it three or four times as strong as usual and pushed it to the limit of producing acute irritation. To control the racking cough till the inhalant could get in its work, I gave a few doses of elixir of white pine and codeine. For "fever drops," to control fever and nervousness somewhat, I put 20 drops of combined specific tinctures of aconite and gelsemium in 4 ounces of water, giving one to two teaspoonsfuls every hour or oftener, "to effect." I also gave tablespoonful doses of "metabolized cod-liver oil" thrice daily for a few days, then changed to "Angier's petroleum emulsion," same doses. As he loathed all food, I gave him for nourishment and general effect, at meal-times, two tablespoonfuls of good sweet oil with Abbott's digestive No. 2, which he forced down. He also ate a few raw and roasted peanuts, as he could.

His pulse ranged from 92 to 96 for four days. Temperature, same time, night and day from 101° to 101.6° F. On the fourth day of treatment, when the lungs were unloading most profusely from the action of the inhalant, the pulse went to 104. Temperature rose to 102° F. for part of a day—in spite of fever drops.

The "unloading" of the lungs continued in greatly increased quantity till the night of the fifth day, when it gradually lessened, as all bad symptoms till now there is little cough or "raising" except in the morning, some "clearing of the throat," etc. For the extreme debility I gave four tablets a day of triple arsenates with nuclein. The sweats stopped the first week. For this I had him sponged on alternate nights with solutions of epsom and common salts—but for all, his general condition was so bad, with weakness and hopelessness, I find entered in my note book on the 18th: "Prognosis doubtful." But there was no doubt among the inmates of two hotels adjoining the open porch on which he slept, whose rest was broken by his severe coughing and raising the first

three nights. All said he could not live and blamed me for not sending him to a dryer climate—for it was damp and rainy here nearly this entire time.

On the 22nd his father came, expecting to "take him home in a box." On the 25th he had a severe attack of pleurisy which we combated with dry heat, pressure to the side and chlorodyne granules, meantime keeping up the other treatment. On the 27th the pleurisy gave way and with it the lungs cleared of the accumulations of the previous two days, when expectoration was too painful. On the 28th my note book says: "Pulse 78, temperature 99° F., lungs nearly cleared and breathing good." Meantime his appetite had come back, reinforced, and he has since been gaining nearly a pound a day in weight, and all symptoms correspondingly improved.

During all this time I kept him practically out of doors night and day. At first, when too weak to sit up much, he lay on a bed in a corner room, high up between two windows whose lower sashes were up, "rain or shine," and at night he slept on an open porch except when very rainy.

As his lungs unloaded, he complained of great pressure across his chest, which I met by forced expansion of sound lung tissue. From this he still suffers some, but there is every evidence of the cavity filling and healing. I still push the inhalant night and day and have done so from the first, more than I should have dared had he not been under my direct control.

After twenty-nine days of treatment, he eats, sleeps, breathes and feels good; weighs 133 pounds. I have been thus specific in the record of this case as I fully realize the criticisms likely to be passed by some in the profession who have not seen its course of progress—"mental reservations" on "errors of diagnosis," "fact and extent of infection"—but from more than thirty years' experience with this disease, and taking into full consideration its history and progress, it was a clear-cut case of what is known down here as "galloping consumption."

Fortunately, in this case the lesions were confined to the lungs where I could reach

all fully with the bromine in the inhalant. I was able to kill the bacilli and clear out the infection, otherwise I am sure that in spite of all the out-of-door life and of improving the nutrition, I should have been like a hunter without a gun and my man would have been in his grave at least ten days.

Of course I don't now consider him entirely cured, although all symptoms, including temperature, the last certain sign, indicate the death of the bacilli and eradication of the infection. He will still take the inhalant and tonics and be under observation for probably another month, till he gets his usual weight and strength—then I shall advise a residence in a more favorable climate than his home, to lessen risk of reinfection, which would likely occur sooner or later should he go back to old conditions.

I realize also that it takes judgment and experience in dosing and regulating the amount of bromine in the inhalant from day to day as the case progresses, in addition to skilful management of the general nutrition, to get the full benefit of this remedy's possibilities; but so long as it is not given strong enough to "burn the throat" or cause acute inflammation and proper time is given between its applications for reaction and elimination of the diseased secretions from the lungs, there is no danger of its abuse. There is more danger of not giving it thoroughly enough to reach the remote recesses of the diseased lungs.

This case simply accentuates the fact which my experience of thirty years has proven, that with a reasonable chance this remedy is a very valuable one in tuberculosis when confined to the throat and lungs.

CHAS. E. DAVIS.

Eureka Springs, Ark.

#### TWO GOOD HINTS FROM IOWA DOCTORS

The doctors who give us these hints do not care to appear in print, but their suggestions will—for the good of the family.

In barber's itch and "jigger" bites try applications of tincture of iron chloride,

full strength. Our informant tells us that this will "knock" both of these troubles.

An application of silver-nitrate solution, 1-2 to 2 percent, is said to be effective in practically all forms of eczema.

Try 'em out and report.

#### GANGRENE OF THE LUNG TREATED WITH CROTALIN, WITH COM- PLETE RECOVERY

Gangrene of the lung is a rare disease and when present is invariably a complication of some other preceding disease, such as pneumonia, emboli, bronchiectasis or pulmonary tuberculosis. The frequency with which it occurs may be judged by those who have the advantage of studying large numbers of hospital cases of pulmonary disease. Au-brech found no gangrene of the lung in over 1500 cases of pneumonia, while others have found three in some 750 cases. From the figures at hand it would seem that the disease complicates pneumonia in about one out of 1000 cases. The mortality of pulmonary gangrene is high, being estimated at from 80 to 95 percent of deaths.

The therapeutic indications are vague. There has never been much that could be done medicinally, and surgery has not produced any startling results. The medication usually employed has consisted of inhalations of creosote and carbolic acid as disinfectants, and oxygen to supply the demand of the tissues. Other treatment has been mostly supportive and symptomatic. The surgeon will undertake to open the chest in cases where the diseased area is plainly near the surface, but even these cases do badly in the majority of instances.

The case which I am about to describe is interesting because of the exhibition of a comparatively new drug and of more importance from the fact of the patient's complete recovery. The following is the case, with a brief history prior to the time I was called to attend.

Mr. R., aged 61, family history negative, occupation merchant. On October 4, 1909, he had an attack of grip with typical symptoms, i. e., general muscular pain, high fever,

etc. Two or three days later pneumonia developed and failed to resolve. It would appear that it was not a pneumococcic infection, but rather one with the influenza bacillus of Pfeiffer. As a result of the unresolved pneumonia, gangrene set in with all its characteristic symptoms of severe cough, stinking sputa and general exhaustion. From October 4 to December 20 the patient had called three physicians to attend him, and was seen by two prominent specialists from New York. All of these gave but one prognosis, namely, the man could not live.

On Dec. 20 I was called in to take charge of the case and found this man very much emaciated, face drawn, anxious expression, and delirious at times; pulse 118, temperature 102.5° F., respiration 42.

Examination of the chest showed dulness over the lower lobe of the right lung, and over same area auscultation revealed numerous large and small moist râles and breathing diminished over the area. General condition: exhausted, appetite *nil*, breathing short and catchy, talked with great difficulty, coughed constantly, with little expectoration; breath exceedingly foul. Heart action weak; second pulmonic sound accentuated; pulse soft, low tension. The odor in the room was putrid.

The above gives a fairly accurate picture of the case before me, and my own prognosis was not much better than that of those who had preceded me, though it was not announced.

The following treatment was instituted: Nourishment consisted of large amounts of eggs and milk added to general liquid diet and cereals. Cold fresh air was supplied from open windows and the room kept between 40° and 50° F. Medication consisted of stimulants, such as strychnine, whisky and brandy or wine, as indicated; glythol in emulsion of glycerin and 15 drops of creosote every three hours. Excessive cough was controlled by codeine.

On the first day I gave him 1-200 grain of crotalin hypodermically into the back of the arm, cautioning the nurse to watch for any redness or swelling of the part and to use

alcohol in form of wet compresses on its appearance. This was repeated every second day for the first week.

At the end of the first week, the pulse and temperature remained about the same, but the general condition was improved; appetite, respiration and mental condition showed marked change for the better. The cough was not so hard and expectoration was increased. During the following two weeks the respirations came down to 28 and 30 per minute, pulse 98 to 100, and temperature ranged from  $101^{\circ}$  to  $102^{\circ}$  F. in the evening with marked remissions in the morning. Expectoration increased in amount and was of a distinctly purulent character and very foul. During this same time, treatment was continued as above outlined. The injections of crotalin were continued every second day but increased to 1-100 grain each dose.

With the fourth week of this treatment, marked improvement came in every way. The most distressing symptom was the profuse expectoration of foul-smelling sputum, but as this was evidently the evacuation of broken-down material, it was looked on as a means toward the end desired, and the prognosis looked very much better. The temperature was gradually coming down and the patient showed some increase in strength. It was during the following week that the greatest improvement was noted. The temperature did not rise above  $100^{\circ}$  F., pulse was 96 and stronger; respirations deeper. The patient took more nourishment and acquired an interest in life. During this time he was allowed to sit up a part of the day. Expectoration grew less and the odor, which was gradually diminishing, had nearly disappeared.

During and after the sixth week the amount of crotalin was increased to 1-50 grain every second day. Improvement continued, the man began talking about going to his business and was anxious to get out of doors. He acquired an appetite and a more liberal diet was allowed. On Feb. 13 he was first allowed to go out and a week later he went to his place of business.

Recently seen at my office, he presented the appearance of robust old age. There

was no cough, he had been putting on weight, and he assured me that he was as good as ever.

R. E. KINLOCH.

Brooklyn, N. Y.

#### SUCCESSFUL MANAGEMENT OF TYPHOID FEVER

Despite the fact that my locks are *not* streaked with silver, no matter if I am one of the younger members of the family, I intend to "come across," as you term it, with an article on the treatment of typhoid fever. Perhaps some of the claims set forth below may be considered as radical or exaggerated, but I wish to state that the following is the routine treatment adopted at the hospital where I served as interne, and I invariably use it now in my practice and so know whereof I speak.

In treating typhoid fever the successful physician always keeps in mind the grandest of medical principles, namely, "clean out, clean up and keep clean." This is best effected by giving, as soon as the first manifestations appear, 1 or 2 grains of calomel in broken doses, followed two hours later by a stiff dose of saline laxative. This medication serves to clean out the alimentary tract, eliminates thousands of bacteria, and makes ready the intestinal mucosa for the next step, "keep clean"—which is readily accomplished by administering, every two hours, 10 grains of the intestinal antiseptics—the compound sulphocarbolates.

Concomitantly with the foregoing I give a mixture of salicylic acid, ammonium carbonate, and elixir of lactopeptine. Determine the amount of salicylic acid you desire to give (be it 5, 10 or 15 grains to the dram), dissolve the acid in the elixir of lactopeptine, and neutralize with the ammonium carbonate. Give of this one or two teaspoonfuls every one or two hours, according to the temperature.

That is all, with the exception of a butter-milk diet, and plenty of water.

Complications: Under the treatment outlined there are no complications, and what is more to the point, your patient will re-

cover much sooner than in the time-honored twenty-eight days.

The salicylic acid is a good bactericide, an antifermentative, and helps to preserve the normal integrity of the intestines; the ammonium carbonate is a fine diffusible stimulant and alkali; the elixir of lactopeptine helps to digest any putrefying material that may happen to be in the alimentary canal.

Under this treatment the tongue cleans up and stays clean, the breath becomes odorless, the fever is promptly reduced, and before you are aware of it, you'll be fighting your patient to keep him from eating everything in sight. Try it, brethren.

"EMBRYO."

—, Illinois.

[The doctor has struck the *principle* which makes for success in typhoid fever, even though his application of that principle is somewhat different from our own. However, in the main we stand on common ground: we both believe in the imperativeness of a thorough "clean-out," and depend upon the sulphocarbonates for the "clean-up." These are the essentials, given a proper diet and good, sensible attention to symptomatic indications.—ED.]

#### A SEWING-MACHINE REVOLUTION

We do not ordinarily undertake excursions into the realm of mechanics, but we have recently seen demonstrations of a new sewing machine (we think it is *new*) that have pleased us so much that we must say a word. This sewing machine is different from the ordinary kind in the fact that the operator sits *directly* behind the stitch line, instead of to one side. As a consequence, there is no leaning over to the left or right, with unnatural distortions and curvatures of the spine which must almost inevitably result when machines of the ordinary kind are used. This means, also, less fatigue to the woman operator—a very great factor when the machine is run hours at a stretch. It also means the reduction of eye-strain to a minimum.

In other words, this is really a "physiologic" sewing machine, providing (as I suppose is the case) that it approaches perfection in other respects also. This machine is made by The Standard Sewing Machine Company of Cleveland.

#### A WELL-DESERVED PROMOTION

We see by one of the Ionia newspapers that Dr. Otis Cope of Bancroft, Michigan, has taken up his residence in Ann Arbor, in order to assume the duties pertaining to the chair of physiology during the absence in Europe, in 1911, of Prof. Lombard.

We feel a personal interest in Dr. Cope. He is the son of our oldest and dear friend, Dr. C. S. Cope of Ionia, Michigan. If he is as good a man as his father, we know that he is absolutely all right. He is a scholarly man and bound to be a successful one, as this new promotion testifies. Our congratulations to both father and son.

#### THE "INDEX-LANCET"

We regret to learn that the Kansas City *Index-Lancet*, of which Dr. John Punton has so long been editor, has ceased to exist. However, we are pleased to know that it has been absorbed by *The Medical Herald* of St. Joseph, Missouri. This excellent publication, so ably managed by Dr. Charles Wood Fasset, will be strengthened by this consolidation. Our best wishes go to *The Herald*.

#### TINCTURE OF ACONITE AS FOUND IN KANSAS

One of our readers sends us a clipping from "Bulletin No. 8" of the State Board of Health of Kansas giving the result of investigations into the character and quality of the tincture of aconite as dispensed in drugstores in that state. We show a photographic reproduction. Fifty-seven samples are reported upon, and there are indeed "fifty-seven different varieties," since no two are alike.

## TINCTURE OF ACONITE AS FOUND IN KANSAS

1235

Bulletin No. 8, August, 1910.

207

## TINCTURE OF ACONITE.

In testing these tinctures, Squibb's physiological method was employed. It was agreed by three operators that a dilution of one part of a standard tincture of aconite in 800 produced a distinct tingling sensation on the tongue. This tincture was considered 100 per cent, and the per cent strength of all other tinctures was calculated from this standard.

Lab. No.	Ins. No.	Per cent strength.	Per cent alcohol.	How made.	RETAILER.	City.
3577	2255	2.5	①		E. R. Brown.....	Eskridge.
3579	2257	30.1	65.4		Dr. Jewett Drug Co. ....	Eskridge.
3581	2259	Below 2.5	64.9		Dr. L. A. Walker.....	Harveyville.
3647	2262②	20.8	66.	From fl. ext.	T. E. Brandon.....	Clyde.
3683	2293	7.8	①		Aigie's Cash Drug Store. ....	Linn.
3686	2296	6.2	60.1	Unknown....	Dr. R. W. Mainy.....	Linn.
3713	2323	20.8	75.		J. E. Janeway.....	Haddam.
3715	2325	15.6	①	From fl. ext.	S. T. Yoder.....	Haddam.
3718	2328	26.	70.1	Bought. ....	J. W. West.....	Narka.
3723	2333	20.8	70.8	From fl. ext.	Bixby & Potter.....	Republic.
3730	2340	26.	70.		D. A. Nywall.....	Scandia.
3733	2343	17.8	73.1	Unknown....	Republic Pharmacy.....	Belleville.
3736	2346	20.	①	From fl. ext.	Arbuthnot & Billingsley. ....	Belleville.
3738	2348	6.2	70.5	Bought. ....	Arbuthnot & Billingsley. ....	Belleville.
3740	2350	20.8	64.8	From fl. ext.	M. G. Reed.....	Cuba.
3742	2352	6.9	65.4		Geo. M. McCleckerson.....	Concordia.
3745	2355	6.9	48.5	" "	W. M. McCarty & Co. ....	Concordia.
3754	2364	50.	65.4	Unknown....	J. G. Trueblood.....	Glen Elder.
3758	2368	6.2	72.4	From fl. ext.	D. R. Seymour.....	Ionia.
3770	2380	3.	①	Unknown....	S. E. Cogswell.....	Kirwin.
3774	2384	6.9	65.9	" "	Dr. L. T. Brown.....	Kirwin.
3779	2388	20.8	71.9	From fl. ext.	Zimmerman Drug Co. ....	Portis.
3783	2393	15.6	67.	Bought. ....	Baldwin & Co. ....	Osborne.
3787	2397	20.8	69.6	From fl. ext.	H. B. Leach & Son.....	Alton.
3790	2400	10.3	66.4		J. B. Hatfield.....	Osborne.
3795	2405	15.6	66.1	From fl. ext.	Thomas Brown.....	Logan.
3800	2410	31.2	73.4	Bought. ....	Smith Drug Co. ....	Stockton.
3808	2418	26.8	72.6	From fl. ext.	G. R. Thomason.....	Stockton.
3829	8371	20.8	72.6		J. P. Roberts.....	McCune.
3837	8379	5.	71.1		Wayne C. Alford.....	Mullinville.
3839	8381	Below 2.5	67.		A. W. McKinley.....	Haviland.
3841	8383	25.	60.9		Pettijohn Drug Co. ....	Haven.
3845	8387	8.1	①		Dodge & Fullmer.....	Ashland.
3846	8388	6.2	①		Rice Bros. ....	Ashland.
3858	8400	10.4	69.3		Junction Pharmacy.....	Coffeyville.
3871	8413	7.8	73.9		Sunflower Pharmacy.....	Independence.
3872	8414	17.4	62.5		L. G. Fowler.....	Independence.
3878	2419	8.8	50.7	From fl. ext.	Forline & Utz.....	Downs.
3888	2429	Below 2.5	74.6	" "	Bunch Drug Co. ....	Beloit.
3894	2435	20.8	72.8	" "	Dr. Clarke Kelley.....	Bonner Springs.
3897	2438	10.4	60.71		Fred Schroeder.....	Leavenworth.
3901	2442	15.6	①		C. L. Walkenwitz & Co. ....	Leavenworth.
3928	8457	2.7	①		Arnold Drug Co. ....	Topeka.
3939	2473	4.7	61.15	Unknown....	Dr. I. J. McCalman.....	Piper.
3941	2475	31.2	66.2	From fl. ext.	C. H. Cain.....	Tonganoxie.
3943	2482	8.3	①	" "	Cleverdon Bros. ....	Leavenworth.
3951	2485	34.7	68.4	" "	R. L. Igel.....	Leavenworth.
3957	2491	6.2	①	Bought. ....	Rebsamen Pharmacy.....	Leavenworth.
3960	2494	Below 6.2	60.		Adolph Lange.....	Leavenworth.
3974	8420	Below 3	66.7		H. S. Mustard.....	Cherryvale.
4004	8450	31.2	59.6		I. L. Graen.....	La Harpe.
4010	8462	3.1	63.4		Owl Drug Store. ....	El Dorado.
4015	8467	6.2	66.		Sollit & Swarts. ....	Arkansas City.
4021	2473	25.	64.8		John S. Cree.....	Arkansas City.
4079	2549③	2.5	62.6	Bought. ....	J. W. Crookson Drug Co. ....	Wichita.
4114	2584	33.	68.3	Unknown....	G. A. Murphy.....	Wichita.
4184	2595	Below 5.	①		C. E. Potts.....	Wichita.

1. Insufficient quantity to determine alcohol.

2. Tincture of aconite leaves.

Bulletin issued by Kansas State Board of Health, showing results of aconite investigation

Using Squibb's tincture as the standard, it seems that not a single sample was up to strength—the nearest is 50 percent, and the next in quality is one of 34.7 percent strength. Ten samples varied between 25 and 34.7 percent; sixteen were between 10 and 25 percent; eighteen between 5 and 10 percent; and eleven below 5 percent.

The official tincture of aconite contains approximately 70 percent of alcohol. Forty-two of these samples exceeded 60 percent in strength, and were, therefore, presumably strong enough in spirit. There were fourteen samples, however, in which the investigators report "insufficient quantity to determine alcohol."

Pharmaceutical authorities have repeatedly advised against the dilution of fluid extracts to make tinctures, yet at least eighteen of these "tinctures" were so made.

About three-fourths of these samples of tincture of aconite were apparently so weak as to be practically inert in the dosage advised in our textbooks. Properly employed, in suitable dosage, aconite is one of the most useful remedies in the *materia medica*; but if physicians generally are depending for their supplies upon preparations like those found in Kansas, there is little wonder that they fail to get results, and so fall into the fashionable heresy of "therapeutic nihilism."

As a rule I do not think that the fault is the druggist's. He is doing the best he can with a class of preparations which, from their very nature, are uncertain and difficult of control.

We leave the deductions to our readers.

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#### AN ESPERANTO BOOK FREE

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Mr. Arthur Baker, editor of *Amerika Esperantisto*, writes us that he has prepared 100,000 brief grammars of the Esperanto language, in pamphlet form, and will send one free to any person who is sufficiently interested to ask for a copy, enclosing stamp for reply. His address is, 700-714 East Fortieth St., Chicago.

We are sure that the interest inspired by the articles already published in our journal will lead many readers of *CLINICAL MEDICINE* to take advantage of Mr. Baker's kind offer.

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#### SECONDARY CATARRHAL PNEUMONIA

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R. McB., aged four years. On March 15 the child had a chill followed by fever, thoracic pain, cough and dyspnea. I saw her the following morning, and upon examination found these conditions: Temperature,  $103^{\circ}$  F.; pulse, 120; respiration, 30; skin, hot and dry; tongue, coated; face, flushed; slight dyspnea; breathing, rapid, causing some distress; cough, dry and unproductive, and an occasional paroxysm ending in vomiting. The physical signs

were those of an acute bronchitis. The breath-sounds were harsh, there was slight lengthening of expiration, sibilant and sonorous ronchi were plentiful in the right lung, but only a few in the left. The urine was scant and highly colored.

The treatment instituted was as follows: Atropine, aconitine and digitalin, to reduce fever; calomel and podophyllin in hourly doses, to evacuate the bowels; the sulphocarbonates for intestinal antisepsis. Emetin and iodized calcium were given to facilitate expectoration; the entire chest was encased in a cataplasma of kaolin.

By the 17th the patient was free of fever, respiration was normal, both lungs were free from mucus, appetite was good, bowels and kidneys were active. She was kept in bed during the day, but some ten or twelve hours later had a chill followed by high fever; the cough was distressing but unproductive; there were dyspnea, slight delirium, headache, and pain in right side.

I saw her two or three hours later, and upon examination found the right lung entirely involved in an acute catarrhal inflammation, but the left unaffected. Persistent headache and delirium marked the course of the disease throughout. On the third day the left lung also showed involvement. Kidneys were sluggish, bowels constipated. Her temperature ranged from  $100^{\circ}$  to  $104^{\circ}$  F.; pulse from 110 to 130, at times weak and irregular; respiration from 25 to 40, shallow and at times labored.

The following treatment was relied upon: Calomel and podophyllin hourly, followed by castor oil, to get free evacuation of the bowels. Daily enemas of warm water and glycerin. Sulphocarbonates of calcium, sodium and zinc, to render the intestines as antiseptic as possible. Aconitine, strychnine and digitalin, to control fever, aided by moderately cold water sponges and ice-cap to the head. Small doses of morphine, cannabis and hyoscyamus, to relieve headache and pain in the side. Emetin, iodized calcium and sanguinarine as expectorants. Arbutin and barosmin were given for inactivity of the kidneys. Nuclein together with the arsenates of iron, quinine and

strychnine were used as stimulants, and during convalescence, as tonic. Milk, chicken broth and beef extract were the principal nourishments. Complete recovery resulted in about ten days.

R. K. OGILVIE.

Blodgett, Mo.

#### ON IMMORTALITY

Anyone who is interested in this subject will do well to procure Dr. C. A. F. Lindorme's little pamphlet, reviewed on page 1146 of the October CLINIC. Address Dr. C. A. F. Lindorme, 287 Gordon St., Atlanta, Ga.

#### FEVER, GALLSTONES AND GRIP SUCCESSFULLY TREATED

In the first place, my experience with the alkaloids has been most satisfactory, both to myself and to my patients. This, however, will not be startling to any of my readers who have taken hold of the active-principle remedies and thoroughly tried them out. I have been using them for eight years and have found them to be reliable.

I am in my twenty-ninth year of practice and have picked up (or picked out) a few therapeutic agents or combinations that have served me well in all cases where indications or symptoms called for them.

In order not to consume the valuable space that others could use, with perhaps more advantage than I, I shall briefly state a few dependable facts that I have come to rely on.

*For fever* I use the following:

Lobelin, 1-12 grain, 1 granule; aconitine, 1-134 grain, 24 granules; bryonin, 1-67 grain, 1 granule; carmine, 1 granule; saccharin, 1-8 grain, 3 granules; and where indications present I add to the above 20 granules of gelseminine, 1-250 grain. I dissolve all in a glass with twenty-four teaspoonfuls of hot water. Directions: One teaspoonful every half to one hour until the fever cools, and then every two hours to keep down the fever. Only one question will come from the reader after looking over

the above antipyretic mixture, and this is, "Why use the lobelin?" My answer is that lobelia is beyond doubt nature's broad antitoxin and hence is a *desideratum* in almost any medication. This mixture, backed good and strong by the "clean-out-and-keep-clean" system which the CLINIC "family" has had drilled into them for years, will work wonders.



DR. C. A. S. SIMS

*Cholelithiasis* (Gallstones). To ease the pain I first rely on dioscorein, 1-8 grain, one granule every five minutes, with one-half glass of hot water, as hot as the patient can drink it. From four to twelve doses relieve the pain, or at least relieve it to such an extent that it is easily tolerated. When this stage is reached I give two or three granules every two or three hours until all pain is gone. I have met with only a very few cases when this was not effective. When opiates have to be used I give full-strength hyoscine-morphine-cactin tablets hypodermically to effect.

Now comes the part of the treatment that you see little written about. I use exclusively

*boldine*, 1-67 grain granules. They do the work effectively. I order two granules taken after each meal, and increase one granule a day (not one a dose) until eight granules are taken at a dose three times a day, or eighteen granules a day. Then I order one granule a day dropped off until a dosage of two granules per dose, three times a day, is reached. I then direct that this dosage of six granules per day be maintained until the patient has taken two bottles of five hundred granules each. This has been my treatment for the past six years and without a single recurring case. Does boldine dissolve the stone? I do not know. I have believed that the dioscorein relaxes the duct and lets the stone pass out into the intestine, almost painlessly, and that the boldine corrects the pathological condition and prevents the formation of the stones.

*The Grip*.—Clean out with calomel, 1-8 grain, and podophyllin, 1-6 grain, of each one granule every half hour for six doses. One-half hour after the last dose give one or two teaspoonfuls of saline laxative in one-half glass of hot water, or, if preferred, hot lemonade. Beginning at the same time that this is taken I prepare the following mixture and administer it:

Lobelin, 1-2 grain, 1 granule; aconitine, 1-134 grain, 24 granules; bryonin, 1-67 grain, 24 granules; gelseminine, 1-250 grain, 24 granules; carmine, 1 granule; saccharin, 1-6 grain, 3 granules.

Put all in a glass and add twenty-four teaspoonfuls of hot water. Directions: One tablespoonful every hour until fever cools, then every two hours until all is taken. I seldom have to repeat this as the grip is gone when the medicine is all taken. I have a large number of grip patients come or send to me for some of "that pink grip medicine," as they have learned to call it. I get the refill and the dollar, instead of the druggist refilling my prescription, times without number.

The one single thing that has served me best of all in my twenty-nine years of practice is physiological suggestion upon one particular point. This is, that I know what my medicine should do for the patient, and

I forcibly impress upon their minds just what it will do. I do this in every case, and it rarely fails to do good. It establishes a confidence that nothing else in medicine will establish. Many are the patients that have said to me when I made the return visit, "Doctor, the medicine did just what you told me it would do when you fixed it up."

There are some few more dependable facts I have at hand that serve me well, but space forbids any lengthening of this "experience testimony."

C. A. S. SIMS.

Kansas City, Mo.

[The doctor strikes a number of therapeutic nails squarely on the head. Here is "experience" that is worth trying out by members of the "family." It should stimulate others to clinical investigation.

The use of boldine in the treatment of gallstones is of special interest. We have long employed this remedy, which has had an enviable reputation among our dosimetric brethren in France, but always in association with sodium succinate, which has assumed in our minds almost the standing of a "specific" in these cases. However, we hope that other physicians will follow out Dr. Sims's scheme of treatment, and report.

Dr. Sims should not keep valuable items like these exclusively under his own hat. They are so good that every reader of CLINICAL MEDICINE will join us, we are sure, in asking for more.—ED.]

#### HEMORRHAGE FROM THE UMBILICUS

The July number of CLINICAL MEDICINE brought to memory a "scare" in my junior year in medical school and the knowledge that a hemorrhage from the navel following detachment of the cord is considered a serious affair. I knew that the laity was afraid of it, but did not know the profession was.

With a preceptor I had attended the confinement of a woman and everything was going lovely. A few days afterward I was telephoned. "The baby is bleeding to death

at the belly-button." I telephoned for my preceptor. He had gone to Michigan. It was "up to me!" I grabbed my "Obstetrics"—could find nothing; "Surgery" and "Practice" were equally barren of any helpful suggestions.

"It can't be much or there would be something here about it."

No street-cars at that time of night, I ran most of the two and one-half miles.

Monsell's solution—failure! Tannic acid—failure! Adrenalin chloride tampon—failure!! And the half-dozen or more skirted calamity howlers that had congregated, coupled with the quiet, hopeless stare of the mother, had me "goin' some."

I grabbed that new obstetrical bag, hoping its contents would give me a suggestion. My hypodermic! Just a few drops of adrenalin solution under the skin, close to the point of hemorrhage, and it stopped like magic. Just staining the area with dilute Lugol's solution, covering with antiseptic dusting powder and a gauze tampon held with adhesive strips, I left the patient.

That was all.

By the time my preceptor returned I had begun to think the incident was of so little consequence, the trick so simple, that I would only get a rebuke for not doing it at first, and I never mentioned it.

Was I the first to use adrenalin chloride hypodermically in such a case? Has it been used in other like cases and failed? Is there anything better?

A. A. D.

[After all, the real test of a doctor is his resourcefulness, which means the ability to add together the scraps of knowledge, *on short notice*, so they'll "work out." Adrenalin is one of the remedies to suggest itself to thoughtful men, but even this seems to

fail in some of these hemorrhages from the umbilical stump. What say our readers?—Ed.]

#### CHILBLAINS AND OTHER ITEMS

Having been a reader of CLINICAL MEDICINE for several years, I wish to contribute a little in return for benefit received.

In all the cures for *chilblains* I have seen, kerosene is seldom mentioned. I suffered severely for years, after freezing my feet, and was finally completely cured by soaking



Dr. C. W. Ihle and his little girl in his "cozy cab"

my feet in clear kerosene for three hours for two successive days. There was absolutely no discomfort afterward. I had tried everything recommended, but with almost no result.

I use the dosimetric granules a great deal and have had some fine results in pneumonia, high fever from autointoxication and in colds.

The "coryza" combination of atropine, aconitine, codeine and quinine is my stand-by for beginning colds. The only trouble is that doctors do not often get colds to treat till they are beyond the stage when they can be aborted.

I have tried calcium sulphide many times, but my results have not been very encouraging. I feel that the wonderful results claimed must be due to other causes. However, I am still using it and do not feel that I have tried it in a thoroughly scientific way as yet.

The arsenates of iron, quinine and strychnine with nuclein have done good work for me with old people.

Calcidin I have used too little to judge, but have had no results in the cases tried.

I have had two cases lately of violent pains, high temperature, badly coated tongue, causing parents great anxiety, in which the clean-up and clean-out treatment has worked well.

In a case of blood poisoning following vaccination in a child, calcium sulphide, calomel followed with saline laxative, epsom-salt baths with ichthyol (50 percent) as a local application proved successful in a short time. Whether the calcium sulphide helped I cannot be sure.

A case of persistent metrorrhagia near the menopause, after curetting and pushing ergot, seems to have been cured by the use of the compound calcium tablets containing calcium chloride and calcium lactate. Before administering these all treatment seemed to fail.

The antispasmodic granule of strychnine, hyoscyamine and glonoin I could not do without. It has relieved many cases of colic, dysmenorrhea and other spasmodic pains. It also helps my asthmatic patients —some more than others, of course.

Some suggestions on urticaria would be welcomed; I have a seemingly intractable case. The same case benefited as to hemorrhage by the calcium compound, but the urticaria is no better. Has a uric-acid tendency, but is not especially helped by treatment on that line.

OLIVE W. BROWN.

Salem, Mass.

[We are very much pleased to hear from the sister-doctor, with her record of successes and failures. She is welcome, and may she come again.

Thanks for the suggestion relative to the treatment of chilblains. This is one of those troublesome things that once in a while yields readily to some simple remedy and "twice in a while" refuses to yield. We have a feeling that in addition to the local medication it is generally wise to look closely

to the nutritive end—bowels, alimentary antisepsis, digestion—and to give remedies that will raise the vascular tone somewhat, as strychnine, digitalin or ergotin. We "suspect" that some of our readers can offer us some valuable suggestions relative to this trouble. Please do so.

The doctor is right—most patients do not come to the physician early enough when a cold is contracted. But even when they come late much can be done if the fundamental principles of treatment are considered—and common sense used. The combination mentioned is an excellent one. Clean out, of course, and keep the skin active.

Dr. Brown is one of the few who report failure with calcium sulphide. She should read the reports of men like Gray of Mexico and Ussher of Asia Minor, who have had simply wonderful success with this remedy. When failure is reported I suspect one of the three things: the alimentary clean-out has not been thorough, the dosage has been insufficient, or the drug itself was not good.

After Dr. Brown has enlarged her experience with calcidin we hope she will report again.

Those cases of urticaria! How they do bother us sometimes, absolutely refusing to yield to the agents which should turn the trick, according to all the rules of the game. We surmise that there is no specific for this trouble and that we shall always have to depend upon a careful study of each individual patient. In the majority of instances a careful study of urine, feces and blood will give the clue. That's where the laboratory comes in. And, as a matter of fact, in every case which puzzles us we should resort to this agency, for the help we are sure to need.—ED.]

#### COLDS AND THEIR TREATMENT

Under the above heading permit me to group acute coryza, grip, with accompanying coryza and all kindred ailments that we are called upon to treat in increasing numbers through the fall and early winter.

The first symptom of an attack of "cold" may be repeated sneezing, which indicates a beginning engorgement of the nasal blood-vessels. Later come the chilly sensations, with aches in the head, back or limbs and which may be mild or severe. There is a "stuffed-up" feeling in the nose and head. The mucous membrane of the nose, if inspected, is seen to be red and swollen, a condition usually extending to the pharynx. There is an irritating serous discharge, generally becoming purulent within twenty-four to thirty-six hours. Labial or nasal herpes may appear, and from inflammation of the pharynx and larynx, the voice becomes husky and swallowing difficult. Fever is generally present, especially in children. Bronchitis with cough is present in many cases. In the simple cases, for which the doctor may not always be consulted, the patients complain only of the irritating "tight" cough and "running from the nose." Ordinary colds often terminate within a week.

Treatment should be directed toward aborting or cutting short the acute attack, restoring normal tone to the mucous membrane of the respiratory tract and maintaining or building up body-resistance.

To abort the attack, a brisk calomel and saline purge, together with a hot foot-bath and the administration of aconitine taken with a glass of hot lemonade, followed by the modified Dover's powder (consisting of morphine, emetine and monobromated camphor) have been used for this purpose with success. While these remedies do not always accomplish the desired result, yet the diaphoresis produced tends toward restoring the normal, healthy balance.

After the cold has developed, nothing relieves the "stuffed-up" feeling as will a brisk spray of an alkaline solvent solution, followed by one of soothing oils, such, as, for instance, the following: Thymol, 0.12; menthol, 0.3; albolene, 60.0. The campho-menthol ointment, containing campho-phenol, eucalyptol, chloreton, menthol and petrolatum, is one of the very best of local applications.

If there be fever with general malaise, rest in bed should be ordered. Aconitine will

relieve the fever, and if codeine is added the nervous irritability will be quieted and the cough checked. A good combination is one consisting of atropine sulphate, gr. 1-100, and calomel, gr. 1-12. Even better are combinations of atropine, aconitine, and morphine or codeine. Such a dose should be given every half hour until the physiologic action is obtained, as evidenced by dryness of tongue or throat, when it is stopped. Later the remedy may be given three to five times daily. For the pain or ache in the muscles and joints, a salicylate should be given. Remove the calomel by saline laxatives.

For the prevention of further attacks the local treatment should be continued until the mucous membrane is normal in color. Potassium bichromate and emetic reestablish a healthy mucous secretion and should be given in doses of 1-67 grain every two to three hours, with hot water. Cold baths with brisk rubbing also aid in preventing recurrence.

When resistance is poor the restorative tonics like iron, codliver oil, nuclein, etc., are to be used. These with nutritious food and good hygiene will restore the bodily equilibrium.

LESTER E. MEE.  
Wilmette, Ill.

#### HOW DR. GRAY TREATS MEASLES

We have just received another interesting letter from Dr. Robert Gray of Pichucalco, Mexico, in which he says:

"I now have the most people I ever had at one time under my jurisdiction, and have the least taxing work to do I ever had, owing to the magnificent preventive method I employ. I have not slept out of my proper bed but twice in forty days; and now is the great epidemic season of fevers, dysentery and measles, everywhere rampant, with high mortality except in my cleaner field, where I have had but one death in six months—a case of black-vomit, the patient being dying when I was called.

"On the subject of measles I am almost afraid to talk, as I sponge the little brats with epsom-salt solution, as hot as bearable,

saturate with calcium sulphide, and push a febrifuge, with pilocarpine, not omitting the cleaning-out process; and they are well in a trice."

We have another splendid paper from the doctor, which we hope to publish in December.

#### ANOTHER FATAL CASE OF UMBILICAL HEMORRHAGE

I read in the July number of CLINICAL MEDICINE that a child having umbilical hemorrhage after the stump comes off means death. I have also read in the August number that G. H. Hoge has successfully treated such a case, with a possibility of the child getting well (page 9:4). Now I wish to report the first case I had of the kind which terminated fatally.

About three months before the 30th of May, 1910, I was called to see a woman with a threatened abortion and who is habitually aborting between the fifth and seventh months and had had three in which the best skill around here was employed without avail. I succeeded in having her bring this case to time, which came on the 30th of May. The child was full-grown but ill-nourished, weighing about four and one-half pounds, and had icterus neonatorum which continued through its term of life although everything possible was done to remove the condition. The child never gained any flesh at all. The navel was ten days falling off, and about six days later I was called and found umbilical bleeding.

In water that was boiled and cooled I dissolved some lysol and with this cleansed the part thoroughly, then dusted the navel with formic iodide and applied pressure with sterile gauze kept in place with adhesive plaster. This was left on for about three days, when I removed the dressing, cleansed the part antiseptically and dressed again, as the bleeding had ceased, the stump, however, being raw. In about nine days the place was healed entirely and the child apparently doing nicely.

Two-days later I was called quite hurriedly, and on reaching the place I found the child

cyanotic and breathing with difficulty. I instituted artificial respiration, and blew into the child's face and mouth, the mother fanning it the while, and soon the blue color disappeared and the child began breathing naturally. Soon another attack came on, and thereafter as soon as one ended another came on until blood came from the baby's mouth and a little from its nostrils. I believed at the time that the bleeding was the result of internal hemorrhage or hematemesis from the umbilicus internally and felt quite reassured when I saw the article mentioned, in the July number. Of course the child died in less than an hour after my arrival.

I also know of a case Dr. Boswell had here in which he made a purse-string suture as did Dr. Hoge, but in spite of everything else he did, the child died. He has been here fifteen years and he says he never saw a case in which the child lived. Of course, being young in the practice, I felt that possibly I did not do all I might have, but now I feel relieved and know that I did everything it was possible to do.

S. T. SEALY.

Mounds, Ill.

#### PNEUMONIA CAN BE ABORTED

For some time I have been a silent reader of your most excellent journal, and I can truthfully say that I have obtained more real, practical, beneficial knowledge from it than I ever did in a class-room, one of the important things learned being that inflammatory diseases can often be aborted or cut short. As evidence I will cite one case of pneumonia lately treated.

I was called to see a Mr. Barrett, aged 28 years. I found him with a typical pneumonia of five days' standing; pulse full, 142 beats a minute; respiration short, and at the rate of 36; temperature, 104.5°F.; cough croupy; a tough brown or bloody expectoration. The patient's tongue was as dirty as I ever saw and his mouth so dry he had to moisten it to talk or to swallow. His cheeks were red as though all his blood had gone to them. The entire right lung

was involved, in fact it was an ugly case of pneumonia in the second stage.

I gave calomel and podophyllin to effect, and alternating with it, aconitine, two granules every one-half hour, and one-fourth of a 5-grain tablet of antifebrin with every fourth dose, directing this to be given regularly until the pulse softened and the skin became moist, then to stop the antifebrin and continue the granules, one every hour until my return. I had his side rubbed well with a coarse cloth soaked with a mixture of oil of turpentine and kerosene, then covered with antiphlogistine. In addition I gave sufficient codeine to make him rest, with a little ipecac for expectoration.

In about sixteen hours I saw the man again. The bowels had moved copiously, mouth and skin were moist, cheeks natural in appearance; I found a soft nice pulse of 92, easy but short respirations, 20 per minute, temperature 99.25°F. I left codeine and ipecac and ordered a dose of castor oil with 10 drops of oil of turpentine to be given the following night. On my visit the following morning I found pulse and temperature normal, tongue nearly clear; patient had rested well and was hungry. I removed the antiphlogistine and found the breathing full except for a slight engorgement persisting in the lower lobe of the lung. There was considerable cough, but free, very frothy expectoration. I left some intestinal antiseptic tablets, had the side rubbed again with oil of turpentine, collected my fees and said good-by.

I have been in regular practice since 1872 and know that had I treated this man according to the old Galenic plan, I should still have him on my hands or else he would be out where all dead folks live. This is by no means my only case of pneumonia aborting but it is the most recent. Seven days after I was called Mr. Barrett rode a rough horse a distance of 28 miles.

I had intended to tell you of some of the good results the H-M-C is giving, but as I have said so much already I shall have to write of this another time. I have not tried urethral bougies. I now have

a chronic case of gonorrhea and shall give them a trial.

Nason, Miss.

G. R. CONNALLY.

[We print the above letter in full in order to show what the regular practitioner can do and is doing in the management of that bugbear, pneumonia, college professors to the contrary notwithstanding. Dr. Connally's thirty-seven years of treatment have taught him to recognize a case of pneumonia when he sees one, so that the objection of "wrong diagnosis" can hardly be raised. We congratulate the doctor on his splendid and efficient treatment, in which we would only suggest the substitution of emetin for ipecac, and hope that he received a good bill, commensurate with the loss of time and the suffering from which the patient was saved.—ED.]

#### SUNLIGHT AND DISEASE

There was smallpox in our community and I was health officer. I did as much as I could to eradicate the evil, but as usual had to deal with a good deal of ignorance and consequently of resistance. On the other hand, I was called in by more enlightened people to diagnose cases which were supposed to be the dreaded disease.

One night a lady came to my office and told me that her daughter was sick, that she had chills, vomited, and had pain in the back and head. I warned the mother that it might be the prodromal stage of smallpox and that it would be advisable to have the girl under close supervision. It was quite late in the evening, so I gave some advice, a little medicine, and waited for a call, which came in the early morning. Etta was worse. Etta is a beautiful girl of a sterling character. I have been their family physician for several years and pride myself of their friendship and confidence. Having seen so many cases of smallpox in India, Arabia and Russia I think I am quite familiar with all the stages of the disease, and so, when I saw my patient, I had no doubt that smallpox was threatening her beauty.

Besides the usual fever and digestive derangement there was a uniform reddening of the skin, of a deeper hue yet on the lower abdomen. The temperature was 104° F., the pulse 96.

If this case had been an isolated one it might not have aroused the well-deserved suspicion, but since I had to deal with an epidemic, and the numerous cases almost without exception presented the same marked symptoms, there scarcely could be any doubt about what was coming.

I at once ordered the room darkened, red cheese-cloth over the drawn shades excluding all sunlight and giving the room a ruddy hue. A miniature lamp with a red shade was allowed in the night. A brisk cathartic was given, and to abate the fevers, tincture of aconite was resorted to. This constituted the only medication, while meat was excluded from her diet.

The fever kept on for two days, now high, then low, a high temperature always initiated by severe chills which shook the bedstead as with giant hands. In the third night she commenced to complain about intolerable itching. "I feel," she said, "as if something is going to break out, measles or scarlet-fever or something of that sort." She did not mention smallpox though, and not a word was said about our suspicions. There was now pain in the throat and an intense feeling of heat.

Slowly the condition improved; then the fever suddenly abated, insomnia disappeared, appetite returned, and after keeping the patient in the red room for two days more she was allowed her freedom. At the end of her illness we told her the reason for the treatment with red light. She was never vaccinated and even now refused to be.

The treatment (prophylactic) by red light by no means is new. Already as early as in 1300 John of Gaddesden, physician to Edward II of England, used the red light. As to my own experience, I could relate many cases in which I have prevented smallpox from breaking out.

I remember one lady, showing the very symptoms, who on the third day insisted on having a ray of sunlight let in to read a

letter from her husband. The nurse, not knowing the extreme importance of the order given, accommodated the lady, and the result was that in less than four hours the pustules made their appearance and the patient was disfigured for life.

We now live in another age, in an age of startling discoveries in every direction. We do not sit down upon the ruins of former greatness, but build up better, finer, greater mansions. And it is our individual duty to help and do our share and contribute a mite to it. And so in talking about light, something came to my mind when I read the Budapest letter in the *J. A. M. A.*, page 611, of recent issue. I read: "Wechselmann's section was located by the innumerable eye-glassed gentlemen who were standing before the door of a large building."

I suggest that all books, all newspapers, all posters, all bills, etc., shall be printed on blue, gray or violet paper; that we shall write our letters, our communications, etc., no longer exclusively on white paper, and that we start as soon as possible in our schools with this—novelty. It is my own firm belief that our thoroughly rooted habit of using white paper has done more harm to our eyes than any other evil and that a cry of warning should go up against the continuance of this custom.

Alas! my alarm cry will be, I know it, as a *vox clamantis in deserto*. But whenever it comes to deeds, you might hear me say, "I told you so."

D. ZWIGHTMAN.

Niles, Mich.

#### PUERPERAL FEVER, PAIN, TONSILLITIS, PNEUMONIA AND LEG CRAMPS

*Puerperal Fever.*—I have found nothing better than to clear out the uterus, then swab it with oil of turpentine. For the fever I give aconitine, veratrine and strychnine, apportioned according to the temperature. As a local wash I use bichloride solution. The turpentine oil at once stops the odor and penetrates the tissues much better than carbolic acid or the bichloride. Never forget the "clean-out-clean-up-and-keep-

clean" part of the treatment, giving small doses of calomel and podophyllin, followed up with effervescent magnesium sulphate, plenty of it, and also the sulphocarbolates.

*Backaches, headaches, shoulder pains.*—I treat my patients at the office with a 500 C. P. leucodescent lamp and Bihlmeier vibrator. I can cure almost any headache in from six to twelve treatments, always remembering the "clean-out-clean-up-and-keep-clean" dictum.

*Tonsillitis.*—Clean out and use ice-water cloths over the inflamed tonsils. Sciatic rheumatism will last only three or four days under the leucodescent light and the vibrator treatments.

*Cold applications and fresh air for pneumonia.*—First thing clear out the alimentary canal. I place my patient by an open window, day and night. If I get the patient soon after the chill, I take a cloth, long enough to reach around the chest, fold it to three or four thicknesses, dip it in a pan of cold water, wring it out and envelop the chest, changing as soon as it gets warm. I keep this up day and night until the fever is gone. By so doing I can often abort the disease. There is practically no filling up of the lungs, and the second and third stages are practically *nil*. I need but little medicine: veratrine and emetin, and sometimes a diuretic. Cold applications relieve all the chest pains.

*Cramp in the legs.*—Slice lemon, rind and pulp, place in a cup, fill with hot water, press out the juice with a spoon and drink before breakfast each morning.

JOHN W. ARNOLD.

Columbus, Ind.

[Fine! But note this: The preliminary "clean-out" and sulphocarbolate "clean-up" are basal features of Dr. Arnold's exceedingly intelligent treatment of every case he reports.—ED.]

#### A CASE OF SHATTERED PATELLA

Mr. J. D. was thrown from a loaded wagon on a steep, rocky hill, when the brake broke. He evidently struck the knee-cap

on a small stone, as I could palpate several fragments on examination one hour later.

After making an Agnew splint for this kind of fracture, I applied it, getting the bones in apposition, as best possible, and ordered the patient brought to my house next morning.

On opening, I found less exudation than usual in these cases, so decided to wait to operate, as possibly I could get good results without doing so. After five days I made a cap for the knee and applied it with plaster of paris from the upper third of the thigh to the ankle, and got my patient out on crutches. After twenty-four hours I cut the plaster and strapped tightly. At this time I examined and found the fragments in apposition, with practically no swelling and little pain.

Three weeks later, while the patient was talking to a "doc" while drinking together in a saloon, he was told the knee wasn't done up right; so the case left my hands, but I expected from the above treatment a good leg.

What do the brethren of the "family" think of the treatment? Textbooks are very meager on this subject.

F. E. McCANN.

Augusta, Mont.

[Here is a question for one of our surgeon friends (or anyone who has had experience), to answer.—ED.]

#### AN "INNINGS" FOR THE POETS

We have an unusually large number of poets—of the really, truly "good" kind—as members of the "family." Hardly a week goes by that one or more of these fails to submit a sample of his (or her) verse for publication—and we're glad to get it. Unhappily, as a rule we are too busy telling one another how to cure ingrowing toe-nails, the itch and other ailments, to court the muses. But we are fond of these fickle ladies just the same. We hope, therefore, that those of our friends whose thoughts flow along in numbers will send us in samples of their verse "as the spirit moves." A few contributions follow:

## THE EAR

The listening ear!  
What fond delights it gathers, brings:  
The carols that the Seraph sings,  
The notes the joyous wild bird wings,  
The stronger tones the organ flings,  
And all the harmony that rings  
To start or dry a tear.

This organ strange—  
What floods of music usher through,  
What sounds resplendent make us view  
What eloquence so grand can do  
When truth recited makes us true  
With all the meaning brought to view,  
Within our mental range.

This marvelous sense—  
Instruction's charm has passed this way,  
The voice of love's soft, gentle lay,  
The song of childhood in its play,  
The merry language, mirthful, gay,  
The rumors which our neighbors say,  
Have all and each a roundelay  
Poured in with life intense.

And thus the ear  
With pain or pleasure heard it all,  
Attentive to each various call,  
Learned secrets which our minds appall,  
Gossips no virtue could install;  
But to the heart none sink and fall  
Like love's sweet charm so dear.

This vital part,  
Made to receive the voice of speech,  
The flow of words which amply reach  
The depth of soul, to know, to teach,  
To importune, persuade, beseech,  
When heart to heart, and each to each  
Is felt the wordy dart.

JAS. A. DEMOSS.

Thayer, Kan.

## "A DOLLAR OR TWO"

The following poem is sent us by Dr. E. S. Haswell of Albany, New York. He disavows the authorship and is unable to tell us who did write it. Possibly some of our readers can give us this information.  
With cautious step, as we tread our way through This intricate world as other folk do,  
May we still on our journey be able to view The benevolent face of a dollar or two;  
For an excellent thing is a dollar or two;  
No friend is so true as a dollar or two;  
Through country and town, as we pass up and down,  
No passport's so good as a dollar or two.

Would you read yourself out of the bachelor crew  
And the hand of a female divinity sue,  
You must always be ready the handsome to do  
Although it should cost you a dollar or two.  
Love's arrows are tipped with a dollar or two;  
And affection is gained by a dollar or two;  
The best aid you can meet in advancing your suit  
Is the eloquent chink of a dollar or two.

Would you wish your existence with faith to imbue,  
And enroll in the ranks of the sanctified few,  
To enjoy a good name and a well-cushioned pew,  
You must freely come down with a dollar or two.  
The gospel is preached for a dollar or two;  
And salvation is claimed for a dollar or two;  
You may sin some at times, but the worst of all crimes  
Is to find yourself short of a dollar or two.

## IF WE BUT KNEW,

There's many a tale of the tongue that's untold  
That trembles to turn tears away;  
There's many a song of the sad soul unsung,  
That sighs to see sorrow still stay;  
There's many a hope of the heart that's unheard,  
That harks to hear heavenly strains;  
There's many a wish of the will unexpressed,  
That wonders why worry remains.

There's many a mood of the mind, that is masked,  
That might move the millions, in voice;  
There's many an agency acting alone,  
At which all the angels rejoice;  
There's many a smile that seldom is seen,  
But some time and some where shall show;  
There's many a love of the life, not unloosed,  
That's learned long lessons below.

The tongue and the soul, and the heart and the will,  
May be each and all out of tune;  
The tale and the song and the hope and the wish,  
Will ah! be forgotten so soon.  
The act is soon ended, the mood is soon gone,  
The smile fades quickly away;  
But the lesson of life is lasting and long,  
Only love is the one sure to stay.

HOMER CLARK BENNETT.

Lima, Ohio.

## THE MICROBE VICTIM

How oft have I scouted the movement of suffrage,  
Denouncing most sharply the idea of clubs;  
I read all the books I could find on those subjects,  
Pronouncing their writers all ignorant dubs.

But one day I happened to swallow a microbe—  
'Twas floating around on the rampage at large!  
It entered my being and seized on my vitals,  
And took its abode in my life, free-of-charge.

And now you can find me whenever I'm wanted  
At large public gatherings in village or town;  
I speak on those subjects 'till folks are exhausted,  
But still I press onward in search for renown.

My husband has left for the high Rocky Mountains,  
And relatives kind have our boy and our girl,  
While I am engulfed in the mad seething waters,  
The home-wrecking waters, the women's club whirl!

"Tis the fault of that microbe,  
That audacious microbe,  
That indigent microbe  
I swallowed that day.

FLORENCE KENNEY EVANS  
Selbyville, Del.

## BEIN' SICK

When I am really sick abed,  
It isn't ever any fun.  
I feel all achy in my head  
An' hate to take my medisun.

I hate for all the folks about  
To come and pat me on th' face  
An' say, "Poor child, you'll soon be out."  
An' tiptoe all around th' place.

They go when I pretend to be  
Asleep—I do it for a trick;  
I don't like folks to pity me  
When I am sick.

My mother's dif'runt—I don't care  
If she sits by me once er twice  
An' says, "Poor boy," an' smooths my hair—  
She ain't just tryin' to be nice.

—*Harper's Magazine.*

## THE SCIENTIFIC LOVER

[“Spray your lips with a carbolic atomizer before kissing,” said Dr. Rurick N. Roark, president of the Eastern Kentucky Normal School, in a recent address on “Habits”, before the Teachers’ Institute. “Thus you will avert danger of death-dealing microbes, transferred by osculation.”—Dispatch in the daily press.]

As the moon looks blandly at us  
From the sky southwest-by-south.  
Let us look well to our status  
And prepare each waiting mouth.  
You, dear, while I lift my visor,  
Lest it punch you in the eyes,  
Hand me, please, your atomizer  
Ere I make your lips my prize.

You will gaze upon the moon, dear,  
In a state of rapt suspense,  
Lest too soon—yes, all too soon, dear—  
I might let my lips intense  
Kiss yours as ere we were wiser  
They were wont oftentimes to do—  
Ere the saving atomizer  
Whispered to us as the cue.

Now, dear, fold your arms about me,  
As I clasp you to my breast,  
Since no health-crunk now can flout me  
As too reckless in love's quest.  
Love is sweet, though Science tries her  
In a multitude of ways,  
Even with the atomizer,  
In these love-by-reason days.

Kiss me once again, my dearest  
(After we have spraved our lips),  
And let not love's feelings queerest  
Meantime suffer sad eclipse,  
Or stop heart-flow like a geyser  
As we fain await our bliss,  
While we use the atomizer  
Just to usher in a kiss.

Hold your finger, while upon it  
I shall place this glittering stone,  
Praying dead love ne'er may pawn it—  
(Spray some more, my sweet, my own!)  
At our wedding, grown still wiser,  
I can reverently say,  
As we use the atomizer,  
Ere I kiss you, “Let us (s)pray.”

EARL MARBLE.

Chicago, Ill.

## SOME NOTABLE MEDICAL-SOCIETY MEETINGS

Different members of our staff have recently had the privilege of attending some of the more important fall meetings of leading medical societies. One of these was the Tri-State Medical Society of Illinois, Iowa and Missouri, which met this year at the Planters Hotel, St. Louis. The President, Dr. William Jepson of Sioux City was detained by illness, and the meeting was ably presided over by Dr. Percy R. Wood of Marshalltown, Iowa. Dr. Walter U. Kennedy of St. Louis was the secretary. This meeting was characterized by a very large increase in membership, for which we are principally indebted to some exceedingly hard work on the part of the treasurer, Dr. Emory Lanphear. The program was a very interesting one, especially notable being the address on surgery by Dr. B. Merrill Ricketts of Cincinnati. We regret that we lack space to describe in detail all the excellent papers that were read. There were no entertainments or dinners—only “just work.” This society has a peculiar appeal to the general practitioner and should be more largely attended. Next year it meets at Fort Madison, Iowa. Dr. Walter U. Kennedy was elected president and Dr. A. S. Burdick secretary for the coming year.

The fifty-fifth annual meeting of the Kentucky State Medical Society met in Lexington, September 26—29. The annual oration was delivered by Dr. Frank Billings of Chicago. Dr. I. A. Shirley of Winchester was president and Dr. J. E. Wells of Cynthiana, president-elect. The literary program was up to the usual Kentucky grade of excellence. There were symposia on cancer, on nephritis, on typhoid fever, on surgery of the skull, on

diseases of the liver and bile passages, on headache, and papers on many other subjects of living interest to the physician. The commercial exhibits were good and attracted much attention, not the least of interest being the presentation of The Abbott Alkaloidal Company. There was Kentucky hospitality throughout the meeting, everything possible being done for the comfort and pleasure of the guests. The visit to the Elmendorf Dairy Farm was greatly enjoyed.

The Pennsylvania State Medical Society met this year at Pittsburg, October 4—6. Nearly 600 physicians were in attendance. The president was Dr. Theodore B. Appel of Lancaster, who, in his annual address, lauded the great strides being made in medicine. As in the Kentucky meeting, the papers were of an unusually high order. Chicago was honored through the presence of Dr. John B. Murphy, whose conservative remarks on the treatment of appendicitis were sensible and to the point. The pendulum is swinging backward toward therapy. There were some fine papers on cardiac diseases, while the discussion of tuberculosis was of special importance. The local members of the profession were lavish in their hospitality; certainly everything that could be done for their guests was done. The commercial exhibits were good and great interest was shown in them. We must not overlook the visit to the Heinz pickling establishment, which attracted many physicians and their wives.

#### **FEASIBILITY OF EXTERNAL VERSION**

At your request a few short remarks on serviceability and practicability of external version. Having performed the "trick" once myself, I will say that it certainly is possible, and nothing could be more useful or practicable when it succeeds—which, however, I do not think it can in all cases.

My patient was a multipara, of medium size and strong, though having somewhat lax abdominal muscles, and in fact the same condition obtained in the uterine walls, except during contractions. She was entirely free from any element of hysteria, and was ideal in behavior, yet absolutely no

progress was made during three or four hours of apparently perfectly physiologic labor. I had previously examined her in a merely perfunctory manner, which does happen sometimes, but now I determined to find out what was the matter.

Having made sure of a transverse presentation, I was successful in my efforts to correct the malposition by external manipulation alone. The patient made short work of the rest of the process of delivery.

EDWARD TRACHSEL.

Denver, Colo.

#### **RATTLESNAKE-WEED**

May I reply to your question on page 1125, October number? The botanical name of "rattlesnake-weed" is *eryngium aquaticum*. Synonyms, button snake-root, rattlesnake master, water eryngo; German *mannstreu*, or *wasserliebende mannstreu*. It is found on the barrens and prairies of the western and southwestern United States. Only the root is used, for decoctions. It is aromatic and pungent in flavor, diuretic and sudorific in effect. In the regions where it grows it has a great reputation as a remedy for snake bites and is used as a household remedy for it.

HENRY RICHTER.

New York, N. Y.

#### **CORRECTION**

In Dr. S. J. Brownson's article, "Economic Factors in Disease," in the second column, page 1119, near the bottom, it is stated that according to the Eighteenth Labor Report unemployment was due to intemperance "in only 26 percent of cases." This should have read "only 0.26 percent of cases." While unable now to determine in what shape the original manuscript of Dr. Brownson's article came to us, the occurrence of the mistake indicated only serves to emphasize the great danger in the growing custom of omitting, in decimal fractions, the cipher that should invariably stand before the decimal point, for it alone prevents its being lost or overlooked.



## CLINICAL MEDICINE POST-GRADUATE SCHOOL *of* THERAPEUTICS

George F. Butler, A. M., M. D., Director   C. E. de M. Sajous, M. D.  
Thomas J. Mays, M. D.   William F. Waugh, A. M., M. D.  
C. S. Neiswanger, M. D.   Alfred S. Burdick, A. B., M. D.

### PART III—LESSON FOURTEEN

#### DIARRHEA AND ENTERITIS

##### PHYSICAL ASPECTS OF DIARRHEA AND ENTERITIS

The Mechanism of Diarrhea is as follows: Either there is a large amount of fluid in the feces, due to their being rapidly hurried through the small intestine, some irritation producing this rapid peristalsis, or there is a too free transudation of fluid into the intestine from the blood-vessels or the glands.

The causative factors are, first, irritants in the bowel-contents, these being of various types, chemical and otherwise; second, irritants acting upon the nerves or nervous system; third, irritants in the blood, as toxins of various infectious diseases.

**Cause of Enteritis.**—This condition is mostly due to chemical irritants, either poisons present in the food when ingested, or derived from the food after ingestion, or present in the blood. There is, however, another class of cases due to pathogenic microorganisms.

In the first group of cases we have those produced by caustic irritants, acids, alkalies, alcohol, phenol, copaiba, camphor, turpentine, and various heavy metals or their salts, including copper, lead, iron, silver.

mercury and a few others. These produce enteritis by directly irritating the mucosa.

Secondly, the ingestion of too much food acting as a mechanical irritant, or through the production by fermentation of caustic acids, and the like. In this class also belong the cases of enteritis produced by idiosyncrasy to particular food, such as milk, or a combination of foods, like fruit and beer.

Thirdly, tainted food: decomposed or putrid fish, flesh, milk, etc., containing ptomaines or toxalbumins when ingested, or which may be produced after being ingested.

Fourth, poisons present in the circulating blood, such as mercury or poisons elaborated within the body; waste products, as in uremia and malaria.

**Infective Enteritis** may be either general or local. As examples of general infection we have typhoid fever, Asiatic cholera, miliary tuberculosis. Local infections are especially gastroenteritis, known as summer diarrhea, or the specific enteritis, caused by the dysentery bacilli described by Flexner, Harris, and Shiga. Among the other organisms are streptococci, colon bacilli, proteus vulgaris, or the bacillus enteritidis sporogenes.

**Diagnosis of Acute Enteritis** (as also of the chronic stage) can be made by an examination of the feces. In acute enteritis the feces are first semisolid, but rapidly become fluid and watery, with a large amount of foul gas. This depends upon the diet. If carbohydrates are ingested, marsh-gas and acids are produced. If milk be the sole diet, there is a characteristic butyric-acid odor. If the disease be located in the colon, decomposition is not so marked and the urine may not contain indican or skatol.

The color of the feces depends upon the presence of biliary pigments and indicates the site of the lesion. A yellowish stool containing much bilirubin indicates an affection of the small bowel, the contents being rushed through so rapidly that oxidation could not take place. In children, under these conditions, the stools are green, due to the presence of biliverdin. This is rare in adults.

A profuse *serous diarrhea*, often practically colorless, occurs in cholera. Mucus is always present, and if mixed with the feces or if bile-colored, the lesion is in the small intestine. If the mixture of the fecal matter is merely colored or coated with mucus, the pathological condition is in the colon or sigmoid flexure.

In an ordinary enteritis, the simple, purely *inflammatory type*, pus is rare and blood is never found. The presence of much unchanged, undigested food indicates an affection of the small intestine.

**Chronic Enteritis.**—The presence of mucus in the feces alone makes the diagnosis; the only exception is enteritis membranacea. Mucoid catarrh, however, may accompany cancer or ulcer of the intestine. If there is no mucus in the stools, there is no chronic inflammation of the intestines. In chronic enteritis there is no pus or blood in the stools, but much epithelium.

**Ulcers of the Intestine.**—These may or may not be accompanied by diarrhea, but ulcers of the transverse colon, descending colon, and sigmoid flexure invariably cause diarrhea. The characteristic findings in the feces are blood, pus, mucus, and frequently fragments of tissue. If the upper

portion of the bowel is affected, the blood may be changed to such an extent as to be only detected chemically.

Typhoidal and dysenteric ulcers are much more apt to bleed than catarrhal or tubercular ulcers.

The *presence of blood* indicates ulcer, unless the patient has had epistaxis, pharyngeal hemorrhage, ulcer of the stomach, or a severe anemia. In all of these conditions blood may also be found in the feces.

The *presence of pus* in the feces is much more characteristic and, except in cases of a rupture of an abscess into the lumen of the intestine, it is pathognomonic of ulceration, either catarrhal or malignant.

*In the presence of bile* in the feces, or if the reaction is highly acid, we have a positive indication of inflammation of the small intestine. The presence of icterus indicates trouble in the duodenum.

The blood does not show anything particularly diagnostic, but may be of value in excluding certain conditions.

In acute enteritis we always have a slight *leukocytosis*. This would exclude typhoid fever, in which no leukocytosis is present. In chronic cases we always have an anemia in which the hemoglobin is decreased to a much greater extent than are the red blood-corpuscles, the result being a low color-index.

In the ulcerative form of enteritis, except that produced by tubercle bacilli, we have a leukocytosis with an increased percentage of neutrophiles. Eosinophilia may or may not be present, and it is usually not very marked unless intestinal parasites are present. *The urine* is usually highly colored and concentrated, showing a high degree of acidity, and if the small intestine be involved, indican usually is present. Albumin and casts are rarely found unless the patient also is suffering from nephritis.

J. F. BIEHN.

Chicago, Ill.

#### THE TREATMENT OF DIARRHEA

**Prophylaxis.**—In persons predisposed to diarrhea by previous attacks, or from ill-health, a change of residence to the moun-

tains or seashore before the beginning of hot weather is the most efficient precaution that can be taken. For infants and children under three years of age living in cities, this is an almost indispensable rule, and many lives may be saved by the timely insistence of the family physician on this point. To prevent a recurrence, the strict enforcement of a dietary regimen suited to the individual capacity of digestion is needed to bring about a permanent cure, and no recovery can be said to be complete until at least a year has passed without a relapse. The question of clothing and avoiding sudden changes of temperature must be dwelt upon, as the patients under consideration are very susceptible to the influence of cold. In every individual case the knowledge of the diathesis will be of service for formulating advice as to diet, mode of living, and the like.

**Clean Intestine the First Consideration.**—The treatment of diarrhea consists, first, in removing any irritant which may be giving rise to it, and, second, in soothing any irritation of the intestines possibly remaining after that. In the case of an artificial diarrhea due to mercurial purgatives, great care must frequently be exercised to insure the removal of the latter. Thus it is the common practice to give a laxative saline the morning following a dose of calomel. This practice is useful not only in insuring the removal of waste products from the intestines, but of clearing out the calomel itself. Sometimes, if the calomel be taken alone at night and no saline in the morning, the calomel will act as a powerful irritant, giving rise to much pain.

**Saline Eliminants.**—Perhaps the most useful remedies for routine use in the *pre-treatment* (if I may coin the term) of diarrheas are the laxative salines. These have the advantage of acting very quickly and practically without the production of intestinal irritation, sweeping out the fecal accumulation or other source of local trouble, and carrying with it a large proportion of the trouble-making microorganisms. If the stools are fetid, or there is reason to believe that there is still a considerable fecal mass left behind, the calomel should pre-

cede; otherwise the laxative saline should be taken at once. If given in effervescent form (as effervescent magnesium sulphate) it has a sedative effect upon the stomach. Children will take readily a laxative-saline lemonade, made by adding a little lemon and sweetening a solution of such an effervescent preparation.

**Value of Castor Oil.**—In the case of diarrhea caused by food, either excessive in quantity, objectionable in quality, or so decomposed in the intestine as to be irritating, one of the best means of stopping the diarrhea is to give a full dose of castor oil together with a few drops (5 or 6) of tincture of opium. The castor oil clears out the intestines thoroughly, irritating matters are removed, while the opium soothes the entire tract and allows it to recover from the irritation.

If in place of a purgative an astringent be given, the bowel movements are arrested temporarily, but the irritant still remains, and if the content consists of decomposing food, its retention only makes matters worse, so that after a day or two the diarrhea will return in a severer form than before.

**Other Useful Remedies.**—Among these one of the principal ones is compound rhubarb powder, if the diarrhea is due to indiscretion in diet. Rhubarb and magnesia act as purgatives and clear out the intestines, while the slight percentage of tannic acid contained in the rhubarb acts subsequently as an astringent. The neutralizing cordial of the eclectics acts very nicely in much the same way. It is now available, in a modified and improved combination, in the tablet form.

When the diarrhea is due to irritation in the mucous membrane of the intestines itself, as in the catarrh which succeeds violent irritation, and not to irritating substances remaining in the bowel, a good treatment is to give a preparation of calomel and sodium bicarbonate, followed by a saline purgative. One good formula is: Calomel, gr. 1-6; iridin, gr. 1-6. Give every hour for four doses. One hour after the last dose give a full teaspoonful of effervescent

magnesium sulphate. Repeat this treatment in forty-eight hours.

**Use of Astringents.**—It must be borne in mind that if the diarrhea depends upon the presence of irritating substances, the use of astringent remedies, such as chlorodyne, Dover's powder (plain or "modified"), Squibb's mixture, or any of the vegetable astringents, while perhaps giving relief for a time, may render the diarrhea more troublesome if they are taken before the irritant contents have passed out.

On the other hand, if the diarrhea has continued for some days and the irritant be already removed, some of the astringents may soothe the intestines and effect a permanent cure. Ordinarily it is not wise to give these astringent remedies, unless an excessive amount of fluid dejecta is passed.

**Diarrhea Due to Mixed Causes.**—In many cases diarrhea is due to more than one cause, as when there are not only irritating substances in the intestines but simultaneously an irritated or inflamed condition of the mucous membrane itself. Here a useful plan of treatment therefore is to give, as the first thing, calomel followed by effervescent magnesium sulphate or a dose of half an ounce of castor oil. If the latter, then one hour afterward let the patient take some hot tea or other warm drink to assist the oil.

After there has been free action, administer a sedative such as the following: Bismuth subcarbonate and sodium bicarbonate, of each 10 grains; spirit of chloroform, 10 minimis; peppermint or cinnamon or clove water, 1 ounce. This dose may be given every four hours, twenty minutes before food (if near meal-time). The remedies mentioned, however, often are inconvenient, so I should substitute here, in many instances, the intestinal antiseptic (compound sulphocarbolate) tablets in connection with soda-mint tablets, ordering one of each every two hours. The intestinal-antiseptic combination is of extreme value in most forms of diarrhea and may be given with advantage to practically every case after the preliminary clean-out.

In case the attack is attended with *fever*, *abdominal pain*, *tympanites*, and frequent liquid stools, the patient should of course be kept in bed, at absolute rest, and not even be allowed to rise for stools.

**The Diet.**—It will influence the progress of the case most favorably if all food is withheld for twenty-four or forty-eight hours, and if only barley water or rice water be allowed in small quantities, as a drink, to relieve thirst. Milk, sipped slowly, should be the first food given at the end of this time, and should be persisted in until the diarrhea has ceased. If not well digested, it may be diluted with lime water, rice or barley water, or made into a gruel with oatmeal or corn-meal. As improvement advances, the exclusive milk diet may be alternated with broths, but no solid foods should be allowed until the stools are normal.

The medicines appropriate to the early stage (and, I might add, throughout any stage of diarrhea) are the intestinal antiseptics, the best of all, in my opinion, being the sulphocarbolates, besides codeine, morphine or hyoscyamine.

**Injections and Flushings.**—Sometimes it may be necessary to wash out the intestinal canal with decinormal salt solution or with a 1:500 solution of the sulphocarbolates. After the expulsion of this solution, 2 drams of a 1:32 solution of aqueous extract of hamamelis in water, should be thrown into the rectum, pressure being made over the anus with a wad of gauze. This alone usually prevents tenesmus, which is very troublesome when the lower bowel is most affected. The good gained by this washing out of the intestines is hardly to be overestimated.

The number and frequency of the irrigation will depend upon the severity of the attacks, as judged by the frequency and character of the stools and by the constitutional symptoms, especially the fever. Two treatments daily may be sufficient, but as many as one every three hours may be needed to reduce the temperature and to arrest the movements and change their character. A lessening in the number of the stools and a disappearance of their putridity are indications

for lengthening the intervals between the irrigations.

**The Abdominal Pain** which frequently accompanies this disorder may be greatly lessened by the application of large hot fomentations or poultices, or better yet what are known as turpentine stupes. In cases where these measures cannot be readily employed, as on a journey; for instance, relief may be obtained by applying a hot-water bag. When a poultice is chosen, it is best not to apply it (as is sometimes done) directly to the skin or with only a thin bit of muslin between it and the body, for then it must either be allowed to become half cold or else the patient's skin will be scalded. More relief is afforded by putting two folds of flannel between the skin and the poultice, in which case it may be made very hot, and the heat, coming gradually through the flannel, does not hurt the patient.

**Carminatives** frequently lessen the pain greatly by rendering the peristaltic contractions of the gut more even, lessening spasm, and assisting the escape of flatus. A useful mixture is 1-2 dram of aromatic spirit of ammonia, 1-2 dram of compound tincture of cardamom, and 10 or 15 minimis of spirit of chloroform. Sometimes a little camphor acts remarkably well as a carminative. The well-known chlorodyne combination owes its popularity largely to the effective use of carminatives. In children one of the best remedies of the class is Waugh's "anodyne."

In cases where *distention of the colon with flatus* is very great, relief may sometimes be secured by passing a long flexible rubber tube into the colon; still, usually the wind may be brought away by injecting some carminative or an enema of oil of turpentine. Probably the best of all injections for the relief of tympanitic distention is the official mixture of asafetida (about 4 ounces), although its disagreeable odor prevents it from being used so frequently as from its great power of relieving flatulence it would otherwise be.

**Food Poisoning.**—Diarrhea due to decomposed food or cheese or to mushrooms is best treated by clearing out the bowel with castor oil or frequent full doses of

effervescent magnesium sulphate, but along with this atropine should be given, because *atropine is an antidote to muscarine* (the poisonous alkaloid of mushrooms) and to other toxic decomposition products of albumin. The 1-100 of a grain of atropine may be given every half hour or hour, either until the diarrhea has ceased or the symptoms of physiologic action have begun to show themselves in dryness of the mouth or dilatation of the pupils. Of course this remedy must be used under constant personal supervision, as it is hardly safe to leave it to the patient's friends to decide when the drug is to be stopped.

**Starving Pathogenic Bacteria.**—I wish to speak of a method of treating bacterial diarrhea other than by intestinal antiseptics. Bacteria seem to have the power of adapting themselves to change of nutriment and of manufacturing new ferments while this is digested, yet a certain time is needed for this adaptation, so if the food be rapidly and frequently varied, the bacteria may in a measure be starved. Thus, when milk has been the diet and the intestine has become infected with bacteria which live readily upon milk, the complete stoppage of milk for a while and substitution for it of farinaceous food exclusively will tend to kill off a large number of the bacteria thriving on milk. After a day or two other bacteria may multiply upon this farinaceous food, but if this again be suddenly changed for meat juice, a great number of these will succumb. Then, by reverting to milk, and repeating the course, all of the noxious bacteria may gradually be eliminated.

**Chronic Diarrhea.**—In all cases of chronic diarrhea the urine should be carefully examined, and if it be found to have a persistently low specific gravity and to contain a trace of albumin, great care must be taken not to check the diarrhea hastily by astringents or other means. In such cases the bowel forms the chief channel for elimination of products of tissue-waste, and if the diarrhea be quickly checked the patient may die of uremia.

**Influence of Temperature.**—In cases of tendency to diarrhea due to cold, or indeed

in all cases of chronic diarrhea or tendency to diarrhea, the abdomen should be kept warm and at an equitable temperature, either by a flannel bandage or by a silk scarf wound several times around the body. Attention must also be paid to the feet, the limbs, and the back of the neck, as a chill in those spots is not unlikely to recall the diarrhea or abdominal pain, even although the abdomen itself be kept warm.

**Nervous Diarrhea.**—Individuals so affected are to be treated by moral remedies. The patient should be encouraged to resist the frequent inclination to defecate, just as a patient with nervous irritability of the bladder is told to resist the desire to micturate. In one particular class of nervous diarrhea, namely that where the introduction of foods into the stomach arouses the immediate desire to go to stool, bismuth taken before meals tends to check the impulse. The same result is sometimes obtained even more easily by the use of 1-2 to 1-minim doses of Fowler's solution, in an ounce of water ten or fifteen minutes before meals, or better still by small repeated doses of strychnine arsenate. Sometimes it may be necessary to add a small dose of codeine, morphine or tincture of opium, but not to exceed what would be equivalent to 1-35 grain of morphine.

**Other Forms of Diarrhea.**—In cases of diarrhea depending on *locomotor ataxia*, small doses of antipyrin may prove useful.

*Malarial* diarrhea, although it resists the usual astringents, and antiperiodics, often readily yields to the arsenates of iron, quinine and strychnine. When in such cases the liver is much enlarged and tender, the cure may be quickened by the administration of calomel, bilein and podophyllin followed by a saline laxative. Thus the congestion of the liver is reduced before the quinine and the triple arsenates come into the field.

*Morning diarrhea* may generally be greatly relieved and sometimes entirely checked by the simple plan of telling the patient to take no liquid after five o'clock in the afternoon. All the liquids should be taken in the early part of the day. Persons, on the contrary, who suffer from *evening diarrhea* should take the liquid late at night and very little

during the early part of the day. In all cases the use of alcohol should be carefully regulated.

In cases where diarrhea depends upon *prolapse of the sigmoid flexure* into the rectum, it should be treated by avoiding all articles of food likely to pass through the intestines undigested and thus irritating to the tender portion of the gut. The bowels may be kept open by means of an enema of 8 ounces of water of normal salt solution in the morning, while immediately after the action an astringent injection of 1 or 2 drams of catechu tincture in 2 ounces of water should be thrown into the bowels and retained there. The mixture previously mentioned, namely, 1:500 solution of sulphocarbonates, with the addition of 2 ounces of calendula, makes a very excellent solution for this purpose. If then this is followed by 2 drams of a mixture of a 1:32 solution of aqueous extract of hamamelis in water, thrown into the rectum as directed above, you will get excellent results.

If there be undue irritation in the sigmoid flexure, some soothing ointment may be introduced into the intestine by means of an ointment carrier. If a short rubber tube be attached to the ointment carrier, the remedy can be passed well up into the sigmoid.

In cases of *obstinate chronic diarrhea*, more especially where dysenteric or ulcers are supposed to be present, large clysters of disinfectant and astringent solutions often are useful. For this reason a pint or more of the solution should be employed in the manner as directed for the softening of scybala. These clysters may consist either of plain warm water, normal salt solution, or a thin starch paste to which are added appropriate sedatives and astringent substances, such as the sulphocarbonates, bismuth carbonate (5 to 10 grains per ounce), boric acid (1 grain per ounce), salicylic acid (1 1-2 grains per ounce), thymol (1-8 to 1-4 grain per ounce), silver nitrate, copper sulphate or zinc chloride (1-2 to 3 grains per ounce). The clyster should be retained as long as it can be with comfort.

Owing to the risk arising from absorption, *powerful poisons* like corrosive sublimate,

mercury iodide or carbolic acid should *never* be used.

**Malignant Disease of the Bowel.**—Here relief may be afforded by a sedative suppository containing atropine, morphine and cocaine. If the diseased part of the bowel cannot be removed, the bowel should be kept open by means of warm-water enemas thrown up high enough to pass beyond the obstruction and soften the feces above, so as to prevent any hardened mass coming down upon the constricted portion and thus giving rise to sudden obstruction. When obstruction threatens, an artificial anus must be made.

When a diarrhea is due to malignant disease of the descending colon or of the sigmoid flexure, relief may be afforded by opening the abdomen and connecting the bowel above and below the diseased portion, so that the fecal matters pass by the affected part instead of through it. The operation of complete excision of the diseased part with union of the ends of the intestine has not been as successful as most of us have hoped.

**Hygienic Measures.**—In the treatment of chronic diarrhea absence from home and from work, change of scenery, mental rest and diversion are very important. Ordinarily such influences, however, are of too short duration to effect permanent results, less than two months' rest and absence being generally ineffective, while in many cases, if neurasthenia is a complicating condition, as it often is, from six months to a year are required. Treatment at home should aim at improving the state of the nervous system and digestion, by recreation, outdoor exercise, especially horseback riding, by massage, light gymnastic exercises, and baths with friction.

As to diet, it may be necessary only to make out a list of digestible foods and one of those articles that should be avoided, insisting upon regularity of eating and complete mastication. In obstinate cases, starch, sugar and salt should be taken in minimum quantities, and the diet of milk, rare scraped beef, rice and light stale bread should be followed for a month before being changed. It is not often that an exclusive milk diet is

required for such patients, although the objection to milk is that it is constipating; but this is no argument against it. The constipation being due to catarrh, no treatment avails until the cause is removed and the diet of milk alone will sometimes be necessary before a cure can be brought about. Pepsin and hydrochloric acid diminish the work of the intestine when taken immediately after food, while some preparations of pancreatic extracts may be of more direct service if given an hour to an hour and a half later.

There is one remedy which acts remarkably well in some of these cases of chronic diarrhea that have persisted for years, and that is, very small doses of mercury bichloride, in doses of not more than 1-100 of a grain.

GEORGE F. BUTLER.

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#### MANAGEMENT OF ENTERITIS

**Get Rid of Intestinal Irritant.**—In all forms of intestinal disease the cardinal principle governing therapeutics is that the existence of irritation presupposes the presence of an irritant.

Removal of the irritant is to be effected by means that in themselves do not add to the irritation by undue stimulation of the inflamed tissues.

Small doses of saline laxatives or castor oil, meet the indication admirably in many instances.

There is nothing better, if as good, as the ancient mixture commonly known as neutralizing cordial reinforced by antiseptics. The following is good:

Sodium carbonate, 1 dram; sodium sulphocarboilate, 1 dram; wine of ipecac, 2 drams; tincture of hydrastis, 6 drams; alkaline syrup of rhubarb, to make 6 ounces. Dose, for an adult, a tablespoonful every two to four hours until the stools become natural, healthy-looking, free from abnormal odor.

No single active principle exactly replaces rhubarb, but this formula may be thus translated into modern parlance:

Juglandin, gr. 1-2; emetin, gr. 1-67; hydrastin, gr. 1-3; copper arsenite, gr. 1-250;

leaving the alkali to be added in form of a bit of baking soda.

**The Best Diet** here is no diet at all, except an abundance of pure water; better taken hot than cold.

If something more is thought necessary, give small cups of very hot strong coffee without sugar or cream, at stated intervals. However, this black coffee is rather to be looked upon as the indicated stimulant than as a food, and replaces all forms of alcohol.

The raw white of egg in cold water is the most likely to be assimilated without needing digestion; give one egg-white every two to four hours.

Barley or rice water does excellently when given every four hours in connection with a little diastase, to insure perfect digestion.

As a rule those foods digested in the stomach are better than those that demand action from the inflamed bowel.

Clear, strained animal broths are useful; consulting the patient's taste as to the selection of oyster, clam, chicken, lamb, etc.

Whenever the attack has lasted over a week begin the daily use of some pure, freshly pressed fruit juices; a gill a day. Use whatever fruit can be had at the time and place and that the patient craves—grape, apple, peach, grapefruit, orange, pineapple.

Any food given should be fed with a spoon, taking a quarter hour to eat (not drink) a gill of it, so that digestion may begin in the mouth.

*Hot applications* over the abdomen and small hot enemas are grateful and aid in relieving the inflammatory hyperemia.

**Combating Inflammation and Fever.**—If intestinal inflammation runs high, it is well to paint the abdomen with iodine or rub in the silver salts, like collargolum.

Fever, headache, pain, nausea, tenderness, with diarrhea, result, usually, from taking cold. Give veratrine, gr. 1-134, every two to four hours. Robust, plethoric persons, with active inflammation, need veratrine in the doses mentioned, to allay the activity of the process.

Vomiting and purging of summer diarrheas often subside under the antiphlogistic

action of minute doses of veratrine, when larger ones would irritate. Aconitine, in similar dosage, replaces veratrine when the latter would irritate the stomach or cause depression.

**The Alvine Discharges.**—Fetid stools, pain and straining, or vomiting due to spoiled fish, etc., demand calomel, gr. 1-6 every half hour for 7 doses; then saline purges.

Clay-colored fetid stools in all cases require these little doses of calomel followed by a saline laxative.

Slimy, bloody stools, with tenesmus and tormina, respond speedily to corrosive sublimate, gr. 1-134 every hour or two.

**Malarial Forms,** and declining stages needing a tonic to the debilitated tissues, do well on cornin, gr. 1-6, every two hours.

Green stools, frequent and painful, with vomiting, and also alcoholics and nervous people, do well on emetic, gr. 1-67 every hour or more. Emetin and juglandin each acts in restoring healthy digestive secretions to replace those vitiated by disease.

Malarial, periodic, and recurrent cases, with jaundice, respond to quinine arsenate, gr. 134, or quinine hydroferrocyanide, gr. 1-67, every hour or two.

Morning diarrheas with cutting pains subside under the use of podophyllotoxin, gr. 1-134 to gr. 1-67 every two hours—big doses irritate.

Dark, fetid stools always call for podophyllotoxin in small, frequent doses. *Don't use podophyllin*, but instead cultivate the pure-drug habit and use podophyllotoxin.

Lienteric diarrheas with gastric irritation respond nicely to sodium arsenate, gr. 1-134 every two hours—for an adult, of course.

Passing food too quickly after eating, undigested, is the indication for the small doses of sodium arsenite or copper arsenite.

Membranous enteritis and dysenteric forms becoming chronic respond to the small doses of arsenic in either form mentioned.

Choleraic diarrhea from cold or bad air and water sometimes demands stimulants, to arouse reaction—monobromated camphor, gr. 1-6 every ten minutes.

Dyspeptic diarrheas, with mucous stools and acute hemorrhoids, do well on anemonin, gr. 1-134 every half to one hour.

**Chronic Forms,** declining stages, with relaxation, often respond well to quassia, brucine or other bitter tonics, in small doses.

Fetid stools, flatulence, of decomposition or fermentation, demand zinc sulphocarbonate, gr. 1 to grs. 5 every one to three hours. The same conditions, with irritability of the stomach or acidity, call for sodium sulphocarbonate in double the doses of the zinc salt.

Declining stages, hemorrhagic, scrofulous or other cachectic cases, do better on calcium sulphocarbonate dosed as the sodium salt.

The three sulphocarbonates apply in about every form and stage of every sort of diarrhea to which man or child is liable; all need disinfection.

Chronic diarrheas, white stools, typhoid and tubercular enteritis, ulcers of the intestines, do well on silver oxide, gr. 1-6 every four hours.

After giving a total of one dram of silver, stop for fear of argyria, and replace it with zinc oxide in triple the doses of the silver. Good also for alcoholics.

Morning diarrheas sometimes subside nicely under rumicin, gr. 1-6 every hour, especially if anemia has supervened.

Bismuth subnitrate is a powerful local sedative and a coat of it over any inflamed surface gives great relief. Give by the dram, if at all.

Infantile and phthisical forms are said to be quickly relieved by helenin, gr. 1-67 to gr. 1-6 every hour till relief is established.

**Opiates.**—The only indication for opiates is to lessen excited peristalsis; morphine is a perilous remedy in any form of bowel trouble. If you must use any opiate let it be codeine, in doses of 1-8 grain, and only enough to restrain excited peristalsis.

Chronic, persistent diarrheas in the aged sometimes do better on copper sulphate, gr. 1-12, every two hours, than on anything else.

Relaxation of the intestinal and gastric walls may demand a few full doses of ergotin, grs. 3 within each twelve hours.

Chronic cases with decided relaxation may require tannic acid. Give 1-6 grain after every stool—the dosing will then be automatically regulated.

**Cotoin and Tuberculosis.**—Cotoin is said to be so exactly suited to true tuberculous diarrheas that when it helps, this diagnoses the case as tuberculous. Give of cotoin, 1-67 grain every hour, until it has afforded the desired relief; then divide the dose into three and give one one-half hour before each meal.

Teething diarrheas, and a few other forms, do well on a little aromatic stimulant, as for instance, menthol, gr. 1-12 every quarter hour till cramps cease.

Somebody with homeopathy on the brain has advised croton oil in doses of 1-134 grain for colicky cases. We do not need it.

Salol, carbolic acid, creosote, resorcin, naphthol, all the older antiseptics, have been wisely replaced by the sulphocarbonates. Better and safer.

Rachitic, tubercular and other colligative diarrheas need calcium lactophosphate, about 15 grains a day, to reinforce the cell-walls.

It is a pleasure to have at hand exactly the right remedy for every form of a malady that may be presented, instead of just something that may do.

Men who use opium or whisky for all diarrheas seem to think they are really physicians!

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#### COMMENT ON THE LESSON

This month the number of students commenting on the lessons is rather small, but the comments which we are printing are long, and, incidentally, excellent. Please read them carefully. By the way, we want to urge those taking the course to submit original material, either in the way of comment or records of experience, with a special view to its appearance in this department.

Next month we shall begin a discussion of the diseases and disorders of the stomach. This is a field of peculiar interest. It is regrettable, but true, that the average phy-

sician is rather at sea when he gets hold of a case of "dyspepsia," so called. The classifications of gastric ailments given in the textbooks seem involved and hard to understand. In our opinion they are made to seem harder than they really are. We shall attempt to simplify, and present the facts in a practical way, which will really aid in outlining treatment. Methods of handling these diseases will be gone into with much detail.

The next few months we shall give up largely to the discussion of visceral diseases, those of the liver and kidney coming first. We shall try to make this course peculiarly interesting. We therefore urge every reader of CLINICAL MEDICINE to begin its study at once and to continue it during the coming year.

Dr. Neiswanger and his colleagues will add their full quota to the course, taking up the physical-therapy side.

**Experience With Smallpox and Vaccination.**—Dr. Theo. Schmalzriedt, of Detroit, Michigan, has given us an unusually interesting paper on smallpox. Dr. Schmalzriedt has had a very extensive experience with smallpox, and we quote freely from his paper. The doctor writes as follows:

"During my eight years' service as health officer of a large and densely populated township immediately adjoining the city of Detroit, I had occasion (from 1900 to 1902) to treat more than 60 cases of smallpox in its various forms of variola confluens, discreta, hemorrhagica and variola sine eruptione; also some cases of varicella and one of vaccinia. (The one hemorrhagic case and one of the discrete cases died; all of the confluent cases recovered.) I vaccinated and caused to be vaccinated several thousand people.

"I had the unusual opportunity of observing the mode of infection, the period of incubation, extraordinary susceptibility to and unusual immunity to the disease, as well as the protective influence of vaccination in quite a series of cases.

"It would involve too much time-consuming labor to go through all of the records, so I will confine myself to abbreviated quota-

tions of excerpts from a paper which I presented in 1900 before the Wayne County Medical Society, relating my experience with 27 cases which had occurred up to that time. My subsequent cases confirmed the experiences with this first series of cases.

"The mode of infection in 19 cases traced has been by direct and close contact. There has been no evidence that contagion was carried by an intermediate person or object.

"In 16 cases observed, the period of incubation varied from seven to twenty-three days, with an average of twelve days in the unvaccinated cases resulting in variola, and of seventeen days in the vaccinated cases resulting in varioloid.

"Extraordinary susceptibility was shown in 4 families consisting of 21 persons, of whom 16 had the disease in some form. The reverse was shown in 3 other families of 18 persons, of whom only 4 were taken sick.

"Instances of immunity were a child of four and a young lady of eighteen who refused vaccination, though continually exposed, a wife and a nurse in whom vaccinations would not become effective and who did not take sick, though continually exposed.

"Of 30 exposed females, 18 contracted the disease. Of 29 exposed males, 9 contracted the disease, showing females twice as susceptible as males.

"Between the ages of two and twelve years there were 2 cases of variola and 4 of varioloid. Between the ages of sixteen and twenty-seven years there were 11 cases of variola and 2 of varioloid.

"The severity of the disease seemed proportionate to the time of and the susceptibility to vaccination. Persons vaccinated early and those in whom vaccination became speedily effective, either escaped the disease altogether or had a very light form of varioloid. Those who were not vaccinated until a considerable number of days after exposure and those in whom vaccination became effective only after six or more days had elapsed, showed a greater number of sick, and these a more severe form of the disease.

"Of individual instances, I will cite the following:

"In the home of Howard P., a farmer, there resided beside himself, his wife, his mother, his sister, his grandfather and a boarder who worked on the railroad. The boarder contracted smallpox. I first saw him when he was in the pustular stage. He had been about the house and at the table during the whole of his illness. We removed him to the smallpox hospital at once, Mr. P. assisting me in placing him in the ambulance.

"I at once vaccinated the five members of the household, this being the seventh day of their exposure. The grandfather had several old vaccination scars and no 'take' resulted. Mr. P.'s mother and sister showed good 'takes,' and remained protected. Neither Mr. P.'s nor his wife's vaccination showed signs of taking, therefore six days after the first vaccination—which was now the thirteenth day after first exposure—I revaccinated both of them. Mr. P.'s first vaccination became effective on the fourteenth day of exposure, the second vaccination on the nineteenth day of exposure. His wife's first vaccination became effective on the sixteenth day of exposure, the second vaccination on the twenty-first day of exposure. Mr. P.'s first vaccination incubated seven days, the second vaccination six days. His wife's first vaccination incubated nine days, the second vaccination eight days.

"On the nineteenth day after the first (and the twelfth day after the last) exposure, which was also the twelfth day after the first vaccination, and respectively, five and three days after the first vaccination became effective, both took sick. His wife, who was eight months pregnant, had a temperature of  $106.2^{\circ}$  F., pulse 180, incessant vomiting. On the second day (which according to Sydenham's dictum would show the tendency of her attack to be of a confluent type) a profuse, scarlatina-like rash covered the body. On the third day vomiting ceased, diarrhea set in, temperature  $103.6^{\circ}$  F., pulse 140. (This temperature was probably influenced by putrefactive toxemia, so common in the latter months of pregnancy, but in 1900 neither I, nor any one of my ac-

quaintances, knew anything about such a condition.)

"On the fourth day she miscarried, child and placenta being delivered before my arrival.

"On the fifth day vesicles were well formed, umbilicated, and showed pustulation on the seventh day. The pustules began to dry up on the ninth day so that by the eleventh and twelfth day the crusts were rapidly cleaning off, showing, beyond doubt, the mitigated influence of the vaccination on the disease.

"On the eighth day her temperature rose and, as the pustules had formed, I took it to be the secondary fever, but by the tenth day I concluded that I had a case of puerperal septicemia. I curetted away some placental tissue, but she continued to grow worse and died on the twelfth day. Autopsy showed some firmly adherent placental tissue, a large number of ulcerous spots, and the walls of the uterus bathed with pus. While vaccination had rendered her disease milder, it was performed too late to prevent it entirely and intrauterine pustulation and placental decomposition ended her life. Her child lived and did not show a mark nor blemish on her body.

"I attended three other pregnant cases of variola confluens and discreta. During their illness these women were respectively six, six and seven months pregnant and carried to full term. Only one child showed about eight or nine deep pits on her body.

"Mr. P. also became sick on the nineteenth day after first exposure. There were chills, high temperature, headache, backache, and extreme weakness. These symptoms would moderate for twenty-four hours and then reappear with the same intensity. This went on for a week and then gradually ceased. No rash nor eruption of any kind appeared.

"Who will question that, under the above related circumstances, this man's vaccination protected him from an attack of smallpox? It is not a supposition, but a case positively proven.

"I could relate other instances, but my report is assuming such length that I will

only cite one other very interesting occurrence—one which goes to show that the physician should not forget himself while taking care of smallpox patients.

"I was successfully vaccinated as a child, some twenty or more years before my attendance upon these cases. In 1894 I was twice unsuccessfully vaccinated. In 1897 I took advantage of an opportunity which presented itself to see a case of smallpox and was again twice unsuccessfully vaccinated. In March, 1900, when the first case appeared, and again in May, 1900, I was unsuccessfully vaccinated. In July, 1900, after having been in close contact with patients while making stethoscopic and digital examinations, getting inhalations of the fetor from their pustulating bodies for long periods at a time, etc., with a number of cases every day for four months, I became somewhat uneasy lest this continual exposure to the disease, together with an enfeebled constitution caused by prolonged strain and overwork of body and mind, should predispose me to an attack of the disease. While not actually sick, I had that 'all in' feeling which denotes that vital resistance was low. I became apprehensive and had a fellow-physician vaccinate me, then went home and vaccinated myself on the other arm. Both vaccinations *took*. Maybe I wasn't thankful that I was not an anti-vaccinationist! My protection of over twenty years' duration had "run out," and but for this fortunate revaccination, in my condition of lowered resistance, I should soon have fallen a victim to my daily exposures to smallpox, I fully believe. I agree with Dr. Waugh when he says, 'I know vaccination protects.'"

**Treatment of Smallpox.**—Dr. R. W. Halladay, North Edmonton, Alberta, Canada, has some interesting things to say regarding the treatment of smallpox. He writes:

"Keep the bowels active by the use of effervescent magnesium sulphate, and as sterile as possible with the sulphocarbonates. Keep up renal elimination by the free use of water, buttermilk and lemonade. Control fever by means of aconitine alone or in combination. Restraine the activity of the

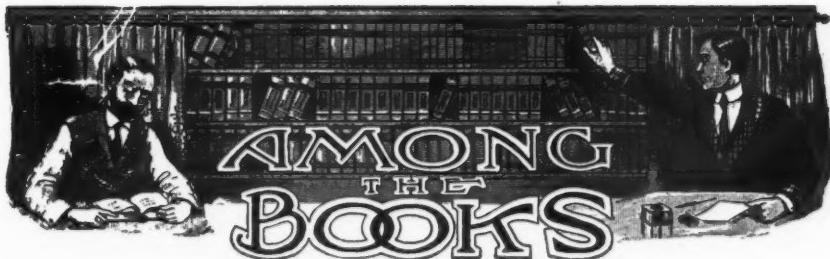
infectious element by arsenic and calcium sulphides, adding nuclein, grs. 10 t. i. d., and echinacea when suppuration begins. Keep the mouth and nose clean by the use of antiseptic sprays. Restraine delirium and excitement by hyoscine or H-M-C hypodermically. Mild excitation is relieved by the valerianates or monobromated camphor.

"Guard the eyes with boric-acid lotions and hot compresses. If adhesion of the lids threatens, smear the edges with yellow oxide of mercury ointment, 50 percent of official strength.

"Diarrhea yields to the sulphocarbonates; if it fails, a few granules of cotoin or lead acetate with opium will be found effective. Restrict the diet to liquids, adding gruels, farinaceous preparations, custards, jellies, etc., gradually, during convalescence."

#### EXAMINATION QUESTIONS

1. What does the color of the stool show in a case of diarrhea? What is the significance of the presence of skatol in the urine? of indican?
2. What is the significance of bile in the feces? of blood? of undigested food? What intestinal trouble may be indicated by eosinophilia?
3. Why should patients suffering from acute diarrhea be given cathartics? Which cathartics are most generally useful and how should they be selected to meet indications?
4. Under what circumstances should astringents be used? Tell of those that you employ and how you use them.
5. What would you give to arrest the pain and tenesmus in a case of acute diarrhea? Suggest some useful combinations.
6. What is your opinion as to the value of intestinal antiseptics in this disease, and how and when should they be given?
7. When are rectal irrigations of value? Tell how to apply this procedure.
8. What is the essential cause of most cases of food poisoning? Why should atropine be used in some of these cases?
9. Suggest a dietetic regimen for a case of diarrhea. Why may some alternation of food be desirable?
10. Describe one case of chronic diarrhea (preferably one that occurred in your own practice) and outline treatment.
11. Give treatment for malarial, tuberculous and dyspeptic diarrheas.



#### HAMILTON-MUNCIE'S "FOUR EPOCHS OF LIFE"

Four Epochs of Life. By Elizabeth Hamilton-Muncie, M. D., Ph. M. New York: Greaves Publishing Company. 1910. Price, cloth, \$1.50 net. This interesting and valuable book is discussed in detail in the editorial department of this issue.

#### COOPER'S "SEXUAL DISABILITIES IN MAN"

The Sexual Disabilities of Man and Their Treatment. By Arthur Cooper. New York: Paul B. Hoeber. 1909. Price \$1.00.

A handy little volume in which the causes and treatment of the various conditions leading to sterility or impotence in man are considered in a clear and dignified manner. The physiology and pathology of the sexual life are discussed with considerable lucidity, showing wide practical experience; the treatment is based upon sound and common-sense principles. The book is useful for the general practitioner.

#### STODDARD'S "THE QUEST"

The Quest. By Dr. Thomas A. Stoddard, Pueblo, Colo. The Cochrane Publishing Company, New York. 1909.

The little volume before us awakens strange reminiscences in the reader, who is wondering whether he is perusing a chapter of Prescott's "Conquest of Mexico" or of Stanley's "Darkest Africa," or whether he has before him a novel intended to while away an idle hour pleasantly.

The author has traveled extensively in that part of South America which is drained by the Amazon and the Orinoco and in which the scene of the principal portion of the story is placed, and it is fully impressed upon the reader that the descriptions of the scenery and of the aboriginal tribes encountered are written from personal observation. We wonder, on following the complications and final unfolding of the quite clever plot, just where truth ends and fiction begins, and are tempted to go and see for ourselves. The few Indian tribes that appear to be descendants of the old Peruvians, dear to us from Prescott's vivid descriptions, are particularly attractive, and the desire to investigate them is strong.

As already said, the plot is clever, although hardly new. A country physician practising in Maine loses his full consciousness through a brain injury received at the hands of a burglar. Functioning in a state of subconsciousness, he makes use of an opportunity to take ship to South America, where he eludes his friends and penetrates far into the interior, being finally found by a tribe of friendly Indians, the descendants of the Incas of Peru, to whom he becomes a teacher, so that they develop the natural resources of their beautiful country in a surprising manner and attain to a high degree of civilization. Here he is finally found—but we do not wish to tell too much since that would curtail the enjoyment to be derived from reading the book.

Somehow we are inclined to forgive the author for expecting us to believe that the civilizing of aboriginal tribes, the complete cultivation of the country, the building of

hospitals, and so on, has all been accomplished in five short years. It is a charming fairy tale with a basis of truth, and like all good fairy tales it has interwoven in its passages many sound thoughts and precepts, especially a strong and emphatic insistence upon the Golden Rule. In spite of the improbabilities and impossibilities we enjoyed the book.

#### "WINSLOW'S "CLEAN MILK"

*The Production and Handling of Clean Milk, Including Practical Milk Inspection, by Kenelm Winslow, M. D., M<sup>•</sup> D. V.; and Essentials of Milk Bacteriology, by H. W. Hill, M. D.* Second edition. New York: Wm. R. Jenkins Company. 1909.

The aim of this book is to provide a working guide for those pursuing or wishing to pursue one of the most wholesome, worthy and laudable undertakings, the production of clean milk. The author is a graduate not only in human medicine, but also in veterinary medicine and in agricultural science, and has had abundant experience in the production and examination of milk, so that he may be said to speak authoritatively. While it is impossible for the general practitioner to keep fully informed on all phases of medicine and the allied sciences, the sister-, or perhaps better, daughter-science of medicine, namely, prophylaxis, is of such enormous importance that he properly feels it incumbent upon him to have at least a sufficient working knowledge of its various aspects so as to be able to give intelligent advice.

In the exercise of prophylaxis nothing may be advanced as of greater importance than the feeding of infants and of invalids, and since milk has always played and probably always will play an important role among the food-stuffs for infants and invalids, it is necessary that the physician should have a knowledge of the chemistry of milk, but still more of the mode of producing it and of the various possible contaminations to which it may become subjected in the transit from the barn to the kitchen. The work before us affords information on all these

and on many other points which are of value to physicians interested in the question of our milk supply; it also is a valuable guide for health officers and for laboratory workers engaged in the examination of market milk.

#### McCURRY'S "PRACTICAL POINTS"

*A Book of Practical Points Gathered from Various Sources, Gleaned from Many Minds, with Chapters on Hookworm and Pellagra.* By J. H. McCurry, M. D. Grubbs, Arkansas. 1910. Price \$1.00.

This is a valuable little volume containing, as the title indicates, practical points from many sources. It shows the value of wide reading and of indexing that which is of merit and importance. The author evidently has the scrapbook habit, and he must have found his collection such a treasure trove for suggestions and for information in his daily work that he decided to let others share in his wealth.

It would lead us too far to indicate in detail the contents of the book; they are as varied as is the experience of a busy practitioner, and are as well selected as a well-ordered brain and balanced mind can perform. In fact the various items and quotations are culled with rare discrimination and aptness, and the whole forms splendid reading for an odd leisure moment, no less than for deliberate study.

The book is well indexed and its value for the reader is increased by its being interleaved for annotations and additions. By all means sit down and mail your dollar to Dr. McCurry; the book is worth it and you will get many times a dollar's worth from its perusal and study.

#### LONG'S "A DOCTOR TO HIS SON"

*Lines from a Doctor to his Son, or Knowledge vs. Ignorance.* By J. I. T. Long, M. D. Published by the author.

A very readable little book of 216 pages which by no means resembles in its tone nor is written in imitation of the books by various putative fathers to their respective

sons, for although it teaches a lot of common sense, these lessons are not couched in the popular slangy language, but the author is terribly in earnest. Neither does he mince matters in condemning in emphatic terms ignorance, laziness, carelessness, and other vices. On the other hand, he is full of sympathy in his advice.

The author is fond of epigrammatic speech. For instance: "You may succeed without money, but you cannot succeed without physical and mental capital." "Seventy-five percent, if not more, of all sickness, suffering and cost [due to them] is avoidable. ... Cancel all the sickness and affliction attributable directly or indirectly to ignorance, plus heredity, and you may turn your hospitals, medical schools and drugstores into business or playhouses. ... It pays handsomely to live close to nature, and it is fearfully costly to transgress her laws."

The author castigates the many sins of commission and of omission in the training of children and adolescents which help to produce the many neurasthenic patients now encountered, and also gives wholesome advice on many important subjects concerning right living which make the book a useful means by which the physician may teach his young charges.

#### KERLEY'S "DISEASES OF CHILDREN"

Treatment of the Diseases of Children. By Charles Gilmore Kerley, of the New York Polyclinic Medical School and Hospital. Second Edition, Revised. Philadelphia and London: W. B. Saunders Company. 1909. Price \$5.00.

In our review of the first edition of this valuable book (1908, p. 137), we said: "To forestall the censure that may justly be raised against the practice of some textbooks copying from one another, the author assures us that the means and suggestions herein are not drawn from the literature but from experience based upon a somewhat extensive application of the principles evolved by the author in private practice." This, we said, is the best reason a book can have for its existence, and this we

say here again, with the addition that the "reason" for this second edition is still greater. We wish this book the widest circulation among general practitioners and specialists.

#### SAALFELD'S "COSMETIC TREATMENT"

Lectures on Cosmetic Treatment. A Manual for Practitioners. By Dr. Edmund Saalfeld, in Berlin. Translated by J. F. Halls Dally, London. With an Introduction and Notes by P. S. Abraham, London. New York: Paul B. Hoeber. 1910. Price \$1.75.

There is no manner of doubt that the branch of dermatology of which the present volume treats is all too much neglected by the dermatologist and still more so by the general practitioner, and that through such neglect not only do both lose a good addition to their income, but their patients are attracted to unscrupulous charlatans, to their financial disadvantage, and generally without any benefit.

It would be well for every physician to familiarize himself with the cosmetic troubles and ills and their proper treatment; his patients expect it of him, and justly so, and his success in such lines will richly repay him. The author is a well-known specialist in this branch of dermatology and offers excellent advice, which has been well translated.

#### THE PRACTICAL MEDICINE SERIES

"Pediatrics," edited by Isaac A. Abt, M. D., with the collaboration of May Michael, M. D., and Orthopedic Surgery, edited by John Ridlon, A. M., M. D., with the collaboration of A. Steindler, M. D. Series 1909, Volume VII.

"Materia Medica and Therapeutics; Preventive Medicine; Climatology," edited by George F. Butler, Ph. G., M. D.; Henry Favill, A. B., M. D.; and Norman Bridge, A. M., M. D. Series 1909, Volume VIII.

"Skin and Venereal Diseases; Miscellaneous Topics," edited by W. L. Baum, M. D., and Harold N. Moyer, M. D. Series 1909, Volume IX.

"Nervous and Mental Diseases," edited by Hugh T. Patrick, M. D., and Charles L. Mix, A. M., M. D. Series 1909, Volume X.

These four volumes complete the series for 1909 of this excellent collection of semi-annual reviews of the literature of the world on the subjects indicated by the titles.

The Practical Medicine Series has become too well established in the favor of practitioners who have neither the opportunity nor the leisure for literary research to need our further recommendation. Its success shows that the books fill their purpose admirably, presenting as they do the most important facts of what is best and most valuable in current literature, while the names of the respective editors, all specialists and acknowledged authorities in their work, vouch for the necessary discrimination in the selection of the material. Only one who has waded through the mass of current and all-too-often ephemeral literature can realize, as the Bookworm fully does, the immense amount of work required to get out these little volumes, and can properly appreciate the excellence and importance of these review-series.

We cordially recommend to our readers to subscribe for these serials, from year to year. They will enable their owner (providing he peruses them carefully) to keep fully in touch with the rapidly changing phases of medical science. The price of the ten volumes of each series is ten dollars; that of each volume, when sold separately, varies from one dollar to one and one-half dollars.

The books are published by The Year Book Publishers, 40 Dearborn Street, Chicago.

#### DUNS' "CARE AND FEEDING OF CHILDREN"

The Practical Care and Feeding of Children. By Mary A. Duns. Second Edition, Revised and Enlarged. Chicago: The Chicago Medical Book Company. 1909. Price \$1.50.

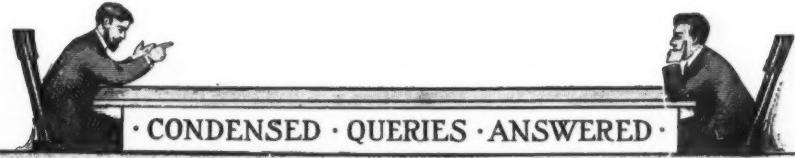
This is one of those books which the physician who has much to do with children should possess in his library for the purpose of loaning it to the mothers of his little patients. The author, a graduate of the Woman's Hospital of Chicago, is an experienced and excellent obstetric nurse and has had a large experience in the care and feeding of children. The subject-matter itself is introduced by some most flattering expressions by well-known Chicago physicians concerning the ability of the author in her chosen field, both as a nurse and as a teacher. We wish her continued success and hope that her book will live through many more editions, for the benefit of the Little Ones.

#### PONCET AND LERICHE'S "RHUMATISME TUBERCULEUX"

Le Rhumatisme Tuberculeux. By Prof. A. Poncet and Dr. Leriche. Paris: Doin et fils. 1910.

For about a dozen years Professor Poncet has persistently called the attention of physicians to what he terms tuberculous rheumatism. When we read his first communications on the subject, we were greatly astonished to find a disease included in the class of tuberculous disorders which we had been accustomed to consider as rather antagonistic to tuberculosis than otherwise. We had even given to our arthritic patients the slight consolation of a promise that they would at least never become tuberculous. Dr. Poncet has changed all that, and, by the force of his persistent researches and of the intensity of his convictions, which he defends with remarkable talent, he has finally succeeded in disturbing opinions that seemed to be well settled.

The task which Poncet has set himself, namely, to prove the tuberculous etiology of certain acute joint affections usually called rheumatic, is by no means easy, for not only do they run counter to the current ideas on the general pathology, but he has failed so far to afford other than clinical proofs in support of his assertions.—Review from *Gaz. des Hôp.*, Feb. 22, 1910.



## • CONDENSED • QUERIES • ANSWERED •

### PLEASE NOTE

While the editors make replies to these queries as they are able, they are very far from wishing to monopolize the stage and would be pleased to hear from any reader who can furnish further and better information. Moreover, we would urge those seeking advice to report the results, whether good or bad. In all cases please give the number of the query when writing anything concerning it. Positively no attention paid to anonymous letters.

## QUERIES

**QUERY 5635.**—"Regional Anesthesia." J. H. L., Indiana, wants a concise work on regional local anesthesia, but no such work seems to exist although there is great need of such a compilation to which the busy everyday practician may turn for information to determine the exact locality where to inject an anesthetic to block, for instance, a nerve-trunk, and the like. He also would like to know the best work on anatomy.

To the best of our knowledge no concise work upon local anesthesia exists. You will find excellent chapters upon this subject, however, in Wharton's "Minor and Operative Surgery," Van Shaick's "Regional Surgery," while most of the other modern works upon minor and general surgery cover the subject of local anesthesia more or less thoroughly.

Several other books of this nature may be mentioned that are excellent and may interest you. "Anesthetics," by Hewitt (London), is one of these. The administration of chloroform, ether, ethyl chloride, etc., is here minutely described. The various accidents which may occur are pointed out, and precautionary measures are suggested. In fact, Hewitt's "Anesthetics" is about the most complete work on anesthesia extant.

Another very practical but smaller book is Boyle's "Practical Anesthetics," published in 1907. And, lastly, a still smaller book (thoroughly practical, however) is "Practical Points in Anesthesia," by Frederick Emil Neef.

As to works on anatomy, Pearsol's is considered by many competent men to be the most perfect work on the subject. This "Anatomy" is a large volume, and the price is \$7.00. Gray's (new edition—Da Costa) makes a very close second. Lee Brothers issue this work. Cunningham's "Anatomy" (Wm. Wood & Co.) has many admirers and is an up-to-date and thoroughly reliable book. The "Atlas and Textbook of Anatomy," in three volumes, at \$6.00 per volume, is a beautiful work, and were the writer purchasing, he should feel inclined to choose these books. For the working physician Eisendrath's "Clinical Anatomy" will prove extremely useful and perhaps be of more practical value than such works as Gray, Cunningham or Pearsol. The price of that work is \$5.00.

**QUERY 5636.**—"Internal Use of Adrenalin." W. L. McL., West Virginia, considers CLINICAL MEDICINE the leading medical publication of the country. He asks what has been the result of the internal use of adrenalin, and if any bad effects have been observed? Has anyone noticed any renal congestion during the use of the drug or afterward? He would be glad to have the opinion of the editor also.

"I am," he says, "the pioneer user of the dosimetric system in this neck of the woods, and although not physically able to do much active practice, still swear by the granules."

In our own practice, using as we do the small dose, bad effects rarely if ever follow the exhibition of preparations of the adrenals.

Sajous, in a very instructive paper published in the *Monthly Cyclopaedia and Medical Bulletin* for February, 1910, remarks:

"The doses advocated may appear small to many. In explanation I can only urge that the power of the adrenal principle as shown by physiological chemists and my own investigation is such that it should be used with the greatest circumspection. Several recently reported deaths from its use emphasize the need of precaution when employing the hypodermics, intramuscular and intravenous methods. Their oral use [i. e. small doses of adrenalin] is at best unreliable. This does not apply to that of the gland itself, nor to the desiccated gland, one grain of which represents six grains of the gland substance. These prove quite effective, though slowly in most instances, when the disorder or condition present actually involves the need of the adrenal principle, to enhance either the oxidizing power of the blood or its immunizing properties."

We agree with Sajous that the principle of the adrenals is such an extremely active agent that it must be used not only in small doses but with considerable caution. We know, of course, that the adrenal principle raises the blood pressure by increasing the tone of the vascular and cardiac muscles. We also know that injections of adrenalin may produce glycosuria or changes in the arterial walls. Sajous points out that in order to define with scientific accuracy the therapeutic use of adrenal preparations, the purpose or function of the adrenal secretion in the organism must be known. As a matter of fact, many effects traceable directly to the adrenals have not been definitely analyzed. The modern therapist finds in adrenalin a most satisfactory constricting agent, hence, uses it largely for the purpose of controlling or preventing hemorrhage. Applied locally to mucous membranes, blanching of the part results, the effect being the stimulation of the muscular fibers in the vessel-walls. It is not followed by relaxation and congestion such as will be noted after the application of cocaine. It should be remembered that adrenalin acts upon the vessel-walls and not through the centric vasomotor influence.

Given internally, adrenalin slows the pulse by stimulation of the vagus and by increasing arterial pressure, owing to the contraction of the muscular coats of the blood vessels. The effect is transitory, however, the drug being unable to maintain its primary influence. By stimulation of the muscular fibers the force of the systole is increased, the effect of the drug being somewhat similar to that of digitalis, but evanescent and less positive. The pulmonary vessels are not affected by adrenalin; the vessels of the uterus are affected, those of the bladder, however, influenced but slightly. The effect of adrenalin upon metabolism is not fully tested.

Bronchial asthma can often be relieved by the injection of 10 minims of 1:1000 adrenalin solution. Not more than this should be given. The drug is also of service in menorrhagia, metrorrhagia, coryza, trachoma, conjunctivitis, congestions of the mucosa generally. Intravenously, adrenalin is employed in cases of cardiac and vasomotor anemia. It is frequently efficacious in the relaxation which sometimes follows chloroform narcosis.<sup>1</sup> In surgical shock, adrenalin should be the first thought. Here we have depression of the vasomotor center and general vascular relaxation. Injections of adrenalin act upon the muscular fibers in the vessel-walls, increasing blood pressure and saving life. Adrenalin, when used in such cases, should be added to normal saline solution, and exhibited intravenously or by hypodermoclysis. Strong solutions, such as, for example, 1:2000 or 1:3000 should never be used hypodermically, the part becoming ischemic, and thus permitting the propagation of bacteria and the formation of slough.

We have not found the use of adrenalin to cause undesirable renal congestion, and as already stated, the drug, intelligently used, is an extremely valuable therapeutic agent.

QUERY 5637.—"Infantile Paralysis or Basilar Meningitis?" In a late communication, reporting a fatal case, a correspondent says: "It is (and was) impossible to procure portions of the brain and spinal cord for microscopical examination. The symptoms of paralysis were prominent in the motor,

but not in the sensory areas; no paralysis of the bladder; reflexes not increased. No girdle pains, no radiating pains of the extremities complained of (except the slight pains in the knees for a few hours already referred to). As his ancestors were a healthy and long-lived people, and he was a strong, healthy boy (none more so in this section), I cannot think there was any tuberculous trouble. He never had any severe sickness, was *always* healthy, no abnormality existed in the nose, throat or auditory canal. If such had been the case I should have informed you of the fact. No trauma, no difficulty in deglutition, nor Cheyne-Stokes breathing, neither spasm of the muscles of the face. Complained of slight stiffness of muscles of back of neck for a very short time, and much less than often complained of from some very trivial cause. Pupils normal, no inequality in size. I cannot think there is any possibility of luetic taint. No typhoid here at present, nor has there been for a long time. Stools normal. Yes, he had been in the harvest field some, but during early part of hay harvest, but made no complaint of the heat. I did not see patient from 5 p. m., Sabbath, till 9:15, Monday morning. He was dead some ten minutes before I reached his home, and I cannot say what may have occurred during that sixteen hours (except paralysis of the left leg), as you cannot always depend upon reports of excited friends. I had no doubts of trouble in the upper part of cord, and perhaps at the base of the brain, but just what it was, was another thing, although the death certificate states "cause of death was meningitis," and has my name attached. I had never met anything just like this in many years' active practice."

The correctness of the certificate cannot reasonably be questioned, but it is extremely desirable in such typical cases, to make a *positive* diagnosis even though one may have to wait for a postmortem to do so.

You are doubtless aware of the fact that a peculiar form of "infantile paralysis" is epidemic throughout the country. Some of the patients stricken have been over fourteen years of age. The symptoms have varied, but a fatal end has been rather the rule.

Should you have any further experience with this peculiar malady we trust you will make careful notes and report the case for the benefit of the profession. The New York State Board of Health has issued an order that all cases of infantile paralysis be reported, terming the present form of the disease "contagious."

Prompt and thorough elimination, the free use of nuclein, echinacea and calcium sulphide, flying-blister along the spine and injections of Unguentum Crede (or intravenous injections of colloidal silver) prove the most efficacious therapeutic procedures.

QUERY 5638.—"Incontinence of Urine." M. M., Indiana, is unsuccessfully treating a case of incontinence in a woman of about twenty-six, dating from the time she was ten years old. Micturition occurs about every thirty minutes in the day-time and almost as often at night. The patient is very nervous and weeps frequently. There is not much pain and little or no smarting. We are asked to suggest the indicated remedies.

Incontinence of urine may be due to any one of several causes. When enuresis diurna and nocturna exist together we may regard the condition as a neurosis, with increased irritability of the vesical musculature and hyperesthesia at the neck of the bladder. In such cases atropine valerianate, brucine and hydrastine will prove efficacious. Nuclein with the phosphates of lime, soda and potassia here prove effective reconstructants. The urine, in such cases, should be examined for hyperacidity and alkalinity. Indigestion, worms, spinal disease, stricture, a distention of the rectum, ocular defects, and so on, must be thought of and excluded. Eye-strain often is at the bottom of such trouble, the fitting of a proper pair of glasses putting a prompt end to the disorder.

A few moments' thought will enable you to see how very liable even the very best physician is to fail in these cases, whereas another may prescribe at random, almost, and stop the leak instantly. Study your patient carefully, making quite sure that

reflex sources of irritation do not exist, then write and give us a clear, concise report, accompanying the same with a specimen of her urine. We shall then be in a better position to suggest the right remedy for the pathologic condition present.

Has this woman borne children or had miscarriages? Is the uterus normal in size and position? Any constriction of the sphincter ani; hemorrhoids or pruritus? Any carbuncle or inflammation of the meatus?

**QUERY 5639.** "Rubeola, Rubella, or Erythema Multiforma." J. C. P., Illinois, was, on July 6, called to see a boy six years old who had fever, sore throat, red skin (hardly red enough for scarlet-fever), small eruptions, and a white-coated tongue; the eruption lasted for four to five days. All the children in the family (four in number) "broke out" in the same way, and there has been quite an epidemic of the disease in the locality. One girl, age twelve, was exposed to measles by another child having it in the same house. She was sick about a day but did not break out any. That was in May. On July 28 the doctor was called to see her and found a temperature of  $103^{\circ}$  F., pulse 120, respiration 18, white-coated tongue, red spots in throat and roof of mouth, white pustules on tonsils, skin eruptions smaller than of measles and the surface reddish or, rather, more of a pinkish hue, which lasted six days. The doctor could hardly give it a name; but as he always treats conditions (not names), gave her the "clean-out and clean-up," and used calcium sulphide, aconitine, phytolacca and echinacea. This is an outline of symptoms and treatment of some twenty cases. Results excellent. What is it?

We note with interest the doctor's experience with an eruptive disease resembling measles. Read carefully, in this connection, Query No. 5600, page 826, July CLINICAL MEDICINE. We are evidently dealing with a condition similar to that encountered by C. S. M., Illinois, i. e., the "fourth disease." It is difficult sometimes to distinguish between a *very mild* scarlet-fever or measles, and a case of German measles, or roetheln.

In the cases described by C. S. M., there is hardly any question that the "fourth disease" existed. This case may, however, have been an erythema multiforma, with autointoxication (which nearly always exists as a prior condition), but we are very much inclined to make a diagnosis of "fourth disease."

If, after reading Query No. 5600, the doctor desires to ask any further questions or present any additional clinical data, we shall be pleased to hear from him. The treatment is very simple and most effective—as he has already discovered.

**QUERY 5640.**—"Magnesium Sulphate and Copper in Antidisenteric Combinations." J. A. B., Oklahoma, was advised by a frère to use, in dysentery, a saturated solution of magnesium sulphate in teaspoonful doses, with 4 to 6 drops of aromatic sulphuric acid added. Soon after receiving this advice he noticed the following formulas recommended for acute dysentery: (1) Copper sulphate, gr. 1-6; magnesium sulphate, dr. 1; dilute sulphuric acid, gtt. 8; water, enough. Directions: Take such a dose every four hours. (2) Magnesium sulphate, ozs. 1 1-2; deodorized tincture of opium, dr. 1; aromatic sulphuric acid, dr. 1; peppermint water, enough to make 4 ounces. Label: One tablespoonful every two hours until stools are free and watery, then every three to seven hours.

The question asked is, "could copper arsenite be used in either one or all of these prescriptions, or if not, could it be used in a saturated solution of magnesium sulphate, and can it be used in lactated elixir of pepsin?"

We certainly should *not use copper arsenite at the same time with copper sulphate*, nor should we be inclined to give copper arsenite combined with magnesium sulphate and opium. Copper arsenite is most valuable when given in small and very-frequently repeated doses, say, 1-3000 to 1-250 of a grain every ten to thirty minutes. As prescription No. 1 contains copper sulphate and a dose is to be taken every four hours, a dose of prescription No. 2 is to be taken every two hours and it contains aromatic

sulphuric acid, copper arsenite would be out of place.

Copper is indicated in all forms of acute diarrhea, but it is especially valuable in dysentery and cholera infantum. We suggest that you read the article on copper arsenite in "Alkaloidal Therapeutics."

QUERY 5641.—"Dosage of Echinacea." M. L. F., Wisconsin, desires to know how long echinacea should be administered and what amount given before stopping?

Echinacea is given to secure a definite result, i. e., to combat systemic infections or to correct depraved conditions of the body-fluids, hence it is rarely exhibited over any great length of time but is pushed in full dosage to effect, say, 1-2 to 2 grains four to six times a day. In septic conditions of long standing the drug may be combined or alternated with nuclein and continued for two or three weeks, dosage being gradually reduced.

The value of echinacea in snake bites, insect stings, etc., has been finally proven. A good preparation of the drug should be given internally and also applied locally. A very interesting article on echinacea appears in Ellingwood's "Materia Medica and Therapeutics," while Lloyd Brothers of Cincinnati offer to supply other pertinent literature.

Echinacea is especially indicated in septic and malignant disorders, in gangrene, sloughing and phagedenic ulcerations, carbuncles, boils, and various forms of septicemia; also in foul discharges with weakness and emaciation. A purplish color of the skin with low inflammation and dirty-brownish tongue call for its exhibition. In typhoid fever, septicemia and other adynamic fevers, in pulmonary gangrene and cerebro-spinal meningitis echinacea is of signal service. Locally it may be used to annul the pain and correct the fetor of cancerous sores. As will readily be gathered from this, the amount of drug given will depend entirely upon the severity of the conditions to be overcome. In every case calling for echinacea active elimination should be secured.

QUERY 5642—"The Salicylates and Oil of Wintergreen." M., Michigan, wishes to know if sodium salicylate is made from true oil of wintergreen. Also what "natural oil of wintergreen" is.

Sodium salicylate (true) is made from the natural oil of wintergreen (also from the oil of birch), and is not to be compared, either in price or in quality with the synthetic product. The natural oil is distilled from the leaves of gaultheria procumbens (wintergreen), a small evergreen plant, endogenous in the northern hemisphere, and bearing scarlet, fleshy, berry-like fruit. If you have ever penetrated the woods of Michigan, you must be familiar with the wintergreen berry. Doubtless as a boy at least you have often chewed the leaves.

These contain the natural oil of wintergreen, a volatile, colorless or slightly yellow or reddish substance with a characteristic strongly aromatic odor, and a sweetish, warm, aromatic taste. It consists almost entirely of methyl salicylate.

True salicylic acid and its salts are obtained from gaultheria procumbens (also, as already said, from oil of birch, *ol. um betulae*), but the market is filled with synthetic salicylates obtained by combining the elements of pure carbolic acid with dry carbonic acid. Sodium salicylate is prepared by the action of salicylic acid upon sodium carbonate. The true sodium salicylate is prepared from salicylic acid obtained from gaultheria procumbens, while the synthetic salt is made from the artificial salicylic acid.

QUERY 5643.—"Adrenalin in Asthma." L. C. M., Alabama, notes that we recommend glonoin followed by hyoscine and strychnine in asthma. "Without criticism of the above," he writes: "Let me request you to try adrenalin solution, 1:1000. Ten drops diluted and injected hypodermically gives relief within ten minutes, and there are no bad after-effects. The patient may suffer with fulness in the chest and a smothering sensation during the ten minutes, but there is no danger and relief is sure. I have used it when the patient would feel the paroxysm coming on and in

fifteen or twenty minutes she would be attending to her household duties. I always recommend the 'clean-out' before leaving the patient. What do you think of the idea?"

We have tried adrenalin frequently. Naturally in some instances it proves effective; in others it does not. In asthma of cardiac origin it may be indicated. Asthma after all is but a symptom and in order to permanently relieve the condition we must remove the cause. Do not forget the extreme potency of suprarenalin. Some very distressing results have followed the exhibition of the quantity you mention. We are glad to note that you insist upon cleaning out the alimentary canal and keeping it clean. This is an essential in all asthmatic cases.

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QUERY 5644.—"Tobacco-Habit." F. H. L., Utah, asks us to "kindly outline the best treatment for the tobacco-habit?"

Treatment of the tobacco-habit depends to a very great extent upon the form of addiction. The man who smokes requires very little if any medical treatment. The amount of tobacco consumed should be reduced until finally the patient finds himself able to refrain from smoking. It is desirable in every case to bring the general health up to the maximum standard, i. e., improve assimilation, increase elimination, equalize and maintain nerve equilibrium. Small doses of atropine or hyoscyamine may be given. These drugs cause a distaste for tobacco. It is essential to meet the conditions present in each individual.

The man who chews can substitute for tobacco some of the preparations of the market. Gum, licorice, rhubarb or gentian root, etc., may be utilized and even given in full doses with strychnine hypophosphite or valerianate to supply the needed tone to the nervous system. Atropine should be pushed until the tobacco becomes distasteful, which it very soon does, then the dose gradually reduced as the desire for tobacco ceases. As a matter of fact any man with ordinary control of himself can cure the tobacco-habit. We have had patients who

were accustomed to smoke and chew incessantly cut the amount of tobacco used in half, reducing each day's supply, at the same time smoking smaller cigars of lighter tobacco, and chewing a small pinch of natural leaf. These men within two weeks have gotten down to one small cigar (a few whiffs smoked at a time) a day, and have chewed a few grains of tobacco at the same time. At the end of the next week they are practically through, and if the influence of atropine is maintained or if the patients are supplied with a few granules and told to take one whenever the desire for tobacco is strong, the third week should see them entirely free from the addiction.

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QUERY 5645.—"Oxaluria." J. H. B., Kansas, sends urine to be tested and desires to know what remedies we should prescribe. The patient is white, male, twenty-four years old and clerks in a clothing store. Teeth are badly affected with pyorrhea. He drinks but little water.

The report of our pathologist shows that the patient suffers from oxaluria. Large quantities of calcium oxalate exist, and there is insufficient output of urea and solids. The main thing is to eliminate and restore functional activity. Give calomel, with podophyllin and possibly bilein, at 7, 8 and 9 p. m., every second or third night for the next two weeks, with a saline-laxative draught the next morning upon rising; boldine, gr. 2-67, and iridin, gr. 1-3, before food. Papayotin in effective dosage after eating, following an hour later with pancreatin and sodium sulphocarbolate.

Keep the mouth thoroughly cleansed with an alkaline antiseptic. A mentholated solution of the sulphocarbolates with a little glycerin added will prove as useful as the various "named" antiseptics—and is infinitely less costly.

Keep the skin active with a daily epsom-salt bath. As soon as you have secured elimination, put the patient upon a generous mixed diet of meat, eggs, milk, fruit and cereals. Ten minims of dilute hydrochloric acid, well diluted, with meats, will prove beneficial at this stage.